PUBLIC MEETING

Ronald Reagan Building and International Trade Center
The Horizon Ballroom
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9:29 a.m.

COMMISSIONERS PRESENT:

SARA ROSENBAUM, JD, Chair
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ALAN WEIL, JD, MPP

ANNE L. SCHWARTZ, PhD, Executive Director
Session 1: Comparing Medicaid Hospital Payment Across States and to Medicare

Chris Park, Principal Analyst

Session 2: Implications of ACA Coverage Expansions for Medicaid DSH Policy

Robert Nelb, Senior Analyst

Public Comment

Session 3: Role of Residential Care Settings in Delivering Long-Term Services and Supports

Kristal Vardaman, Principal Analyst

Public Comment

Session 4: Improving Service Delivery to Medicaid Beneficiaries with Serious Mental Illness: Themes from Roundtable Discussion

Katie Weider, Senior Analyst

Session 5: The Relationship Between Medicaid Financing and Provider Payment Policies

Moira Forbes, Policy Director

Chris Park, Principal Analyst

Public Comment

Session 6: Review of Children’s Coverage Recommendation Package: Draft Specifications

Joanne Jee, Principal Analyst

Public Comment

Adjourn
CHAIR ROSENBAUM: All right. We are going to come to order. Good morning, everybody, and welcome to the September MACPAC meeting. We have a very full day in store for everybody. Because there is so much material being covered, we have set up the day with two very substantial briefings and then a public comment period following the first two briefing sessions. And those two briefing sessions, of course, deal with hospital payment issues.

We will then have a brief session on residential care followed by another brief comment period. In the afternoon we pick up with a session on beneficiaries with serious mental illness and come back around to the question of Medicaid financing, this time looking more generally at the relationship between Medicaid financing generally and provider payment policies.

There is a public comment period after that, and then our final session of the day will be a review of children's coverage and possible recommendations moving toward a draft specifications package, followed by a final public comment.
So a full day, and why don't we get started with Chris Park.

### COMPARING MEDICAID HOSPITAL PAYMENT ACROSS STATES AND TO MEDICARE

* MR. PARK: Thank you, Sara.

As part of our payment work, we have frequently been asked questions on how a state's hospital payments compares to other states as well as how Medicaid payments for hospitals compare to other benchmarks such as Medicare. To address these questions, we worked with the Urban Institute to construct a state-level payment index to compare fee-for-service hospital payments, inpatient hospital payments across states, and to compare Medicaid payments to Medicare.

Even though states have expanded their use of managed care in recent years, fee-for-service payment rates are still important to understand. Fee-for-service hospital payments were about 18 percent of total Medicaid spending in fiscal year 2014, and fee-for-service payment rates are often the basis for the managed care plans' payments to hospitals.

This work would be one of the first attempts to
do a comprehensive comparison of inpatient hospital payment across states and is similar to the work that Steve Zuckerman and his colleagues at the Urban Institute have done for Medicaid physician services. We think that this analysis can also serve as a foundation for MACPAC's future work on payment adequacy and the relationship of payment to measures such as access, value, and quality.

Today's presentation will go through the data and methods used to create the payment index and demonstrate how hospital payment can reflect a considerable amount of variation in payment policies. I will then discuss the steps we took to account for supplemental payment and provider contributions in trying to assess net payment to hospitals. And, finally, I'll present our comparison to Medicare rates.

This work also links to our subsequent discussion today on disproportionate share hospital payment policy and the relationship between payment and financing.

In terms of creating the payment index, we used 2010 Medicaid analytic extract data. This was the most complete set of data that we had at the time when we started this analysis. The MAX data is a cleaned-up
version of the Medicaid Statistical Information System data that we typically use for research purposes. We focused on fee-for-service acute-care hospital stays for enrollees who were under 65 and not dually eligible for Medicaid and Medicare. We excluded the dually eligible since Medicare would have been the primary payer for most of their hospital stays. We excluded those eligible on the basis of age as the majority of these individuals were dually eligible, and the remaining population of non-dually eligible enrollees resulted in small sample sizes in most states.

We additionally excluded stays for rehabilitation, long-term care, and psychiatric hospitals to further reduce variability across states in terms of payment associated with different hospital types. And, finally, we excluded managed care stays because the MAX data do not contain payment information on how much the managed care plans paid providers.

Because states use different payment methodologies to pay for inpatient hospital services, such as per diem, cost basis, and diagnosis-related groups, there is not a set of standard billing codes used across
all states, so we needed a consistent and comparable way to identify what condition was being treated and what services were being provided during a stay across all states. To do this, we classified all of the claims from all the states using the All Patients Refined Diagnosis Related Groups, or APR-DRGs. We also made adjustments to control for price differences across markets and differences in enrollee characteristics and case mix.

We made a wage adjustment to account for differences in local prices and wage rates across and within states, and we used the Medicare methodology to do this. So we used the local wage index data from CMS' Inpatient Prospective Payment System and the hospital labor share to make this adjustment.

We also made a case mix adjustment to control for differences in the mix of enrollees and the acuity and severity of admissions across states. The details are on this slide that I won't necessarily walk through in great detail, but one way to think of this is analogous to risk adjustment, so we are trying to control for the different populations across states.

To construct the payment index, we calculated
wage and case mix adjusted average payment per state for each state. Then we divided each state's average payment amount per state for all states -- we took the average payment amount for each state and divided it by the average payment amount for all states. So this created an index value which provides a relative value compared to the national average. For example, if the index value in a state was 1.10, that means it was 10 percent higher than the national average.

This graph shows the results from our payment index, and the payment index ranges from 0.49 in New Hampshire to 1.69 in Washington, D.C. While this is a wide range, I should note that the most recent Zuckerman study on physician fees also showed a very wide range in payment rates, ranging from 0.57 in Rhode Island to 2.54 in Alaska. So this isn't necessarily an uncommon distribution across states.

Because our payment index focuses on average payment, it masks some of the considerable variation in payment policies and amounts within any given state. There are variations in state payment policy within a state, which means that states are not consistently high or low
payers across all conditions and services. Some states have made specific policy adjustments to increase or decrease payment for particular services to support policy goals. For example, Tennessee and Washington have lowered payment for cesarean deliveries in recent years as part of initiatives to reduce C-sections and early elective delivers.

Additionally, state payment for a particular condition may vary across hospitals. This payment may vary by hospital because the payment methodology is inherently hospital-specific, such as a cost basis, or the state assigns hospitals different base rates under a DRG-based methodology.

To take a closer look at this in-state variation, we selected a sample of 20 high-volume, high-dollar DRGs and severity subclass combinations. We calculated a wage-adjusted payment index for each of the 20 APR-DRGs, and we didn't have to do a case mix adjustment in this process because each of the APR-DRGs are inherently case mix adjusted because they are for a specific condition and severity.

So here we show the correlation coefficient
between the 20 individual APR-DRG indices compared to the overall base payment index, and we use this to try to judge how well each of the different conditions compared to the overall payment index. And for the most part, most of the 20 APR-DRGs had a moderate to fairly strong relationship to the overall payment index based on the correlation coefficient being over 0.5.

However, there were exceptions, and here we just show a few examples of how the overall index compares to three different conditions of appendectomy, diabetes, and cesarean section. And we left the states de-identified at this point because we just want to show examples of how this variation across states and within states can take place, and we didn't want to focus on any particular state at this point.

For example, State A here was a fairly high payer on the overall index with a state ranking of seven, which means that they were the seventh highest paying state on average. But as you can see in the circle sections, they were fairly low for appendectomy and cesarean section.

State B was in the bottom third of payers in terms of the overall index, but they were fairly high on
diabetes.

State C, you kind of see how they were both high on appendectomy and low on diabetes compared to their overall rank.

And then State D was very low on almost all the services, but they were fairly high -- like around the middle -- for appendectomy.

This slide shows a box and whisker plot that shows the variation of payment within a state for a particular service. So in this case, we are showing an example of the cesarean delivery payment. And so the rectangle showed the 25th to 75th percentile range of payment. And so you can see from the two states that I've circled in red how wide this payment range can be in certain states, versus, you know, here kind of circled in dark blue for Indiana and Michigan, you see a very tight range, which means that they don't have much in-state variation across hospitals for this particular service.

And so, you know, you can see how these 25th to 75th percentile ranges overlap across states and how for certain states the hospital distribution mix that you capture within the time period you are analyzing can make a great
difference in how their average payment would come out.

So all the comparisons I've shown you so far have focused on the base payment made to hospitals through the claims process system. This ignores the supplemental payments to hospitals, and these supplemental payments are substantial. In 2014, about 44 percent of total hospital payments were made through supplemental payments, and these are frequently made on a lump-sum aggregate basis, and claims data in the MAX information that we had did not contain the information for supplemental payments.

While we do have information on the aggregate amount of supplemental payments at the state level through the CMS-64 Financial Management Report, we do not have good information on the amount of supplemental payments made to individual hospitals.

Another challenge associated with supplemental payments, they're frequently used with non-federal financing options, such as provider taxes, certified public expenditures, intergovernmental transfers. And so because the provider is contributing a portion of the non-federal share, we need to take these into account to get to a net payment that these providers actually receive once you
As I mentioned before, we have state-level supplemental payment data from the CMS-64 Financial Management Report. However, not all states consistently break out the supplemental payments to hospitals. They may report in one lump sum for both base payments and supplemental payments. So this makes a comparison difficult because, depending on how the state reported the data, you may get different results. So we created two different methodologies to try to take supplemental payments into account.

The first methodology grosses up the base payment from MAX to match the CMS-64 total in aggregate. And so this makes an adjustment even if the state doesn't report supplemental payments separately. However, this potentially grosses up base payments as well even if a state did not make a supplemental payment.

The second method grosses up base payments in MAX using a ratio of total inpatient payments to regular inpatient payments in the CMS-64. One of the benefits of this is it keeps the claims payment amount the same from the MAX. However, it doesn't work well if the state does
not report supplemental payments separately. And because we're using state-level data, we make both of these adjustments equally -- you know, the same factor gets applied to all hospitals and all cases that we have in our data.

Because of the supplemental payment adjustment, we ran four different scenarios. The first scenario is the unadjusted base payments, which I just showed you. Scenario 2 and 3 are the two different supplemental payment methodologies that I just walked through. And Scenario 4 takes Scenario 3 and tries to calculate net provider payment by backing out provider contributions using data from a 2014 GAO study.

So this slide just shows you how the adjustment and assumptions that we make really matter across states. We're looking at the four different scenarios for six different states. And so State A here was the highest-ranked state on the base payment scenario, and once you make the adjustments, you know, they come out to be seventh on the net payment scenario. But, you know, they are in the teens for the two different supplemental payment adjustments.
State B is kind of the opposite. They were near the middle on the base payment scenario, but once you take net payments into account, they were ranked number one.

States C and D are just kind of some of the average cases where they have some variation across the different scenarios, but they maintain a kind of same relative position among states.

State D was just kind of the lowest on both the base and net payment scenario.

States E and F really show the effect of the two different supplemental payment methodologies. As you can see, State E was near the bottom under Scenario 2 but near the top under Scenario 3, and vice versa for State F. They were near the top for Scenario 2 and near the bottom for Scenario 3. So because of our lack of data at the provider level and the assumptions we are making, the methodology does make a big difference.

So the other question we are frequently asked is how Medicaid payment compares to other payers such as Medicare. And so to make this comparison, we used the fee-for-service Medicaid stays for non-elderly adults eligible for Medicaid on the basis of disability. We wanted to
limit the population by taking out the children and pregnant women and other adults who are less like the Medicare population.

We also classified the Medicaid claims using CMS' Medicare DRG group or the MS-DRGs, and we did this so that we could match -- make a closer match to how CMS classifies and pays for stays.

We got the Medicare payment from CMS' Medicare provider utilization and payment data set that they've released, and we used the inpatient data for fiscal year 2011. We used the average total payment from this data set, and this data set contained payment information for the top 100 most frequently billed Medicare MS-DRGs by provider.

From this list of the top 100 DRGs, we focused on 18 high-volume MS-DRGs for both Medicaid and Medicare, and we also included hospitals that are in both data sets due to some of the variation across hospitals that I mentioned earlier. We wanted to try to make this comparison as close as possible by looking at the specific conditions and specific hospitals that were comparable across both data sets.
And we also weighted the Medicaid payments by Medicare volume at the hospital MS-DRG level to calculate, you know, a total national payment across the same mix of services and hospitals. By doing this, we found that Medicaid base payments were, on average, at the national level 78 percent of Medicare.

However, this is a bit misleading because the Medicare payment was the total Medicare payment and contains the supplemental payments that are made in Medicaid, such as Medicare DSH and GME amounts. All of these are paid through the inpatient prospective system and so were included in the total amount that we're able to get from the CMS data set. However, we haven't made our adjustments on the Medicaid base payment side, so none of the non-DSH or DHS supplemental payments have been taken into account at this point.

This graph kind of graphs the average Medicare payment on the X-axis versus the average Medicaid payment on the Y-axis, and the diagonal line kind of distinguishes where Medicaid or Medicare is a high payer. And so anything below that diagonal line indicates that Medicare is a higher payer than Medicaid. And so as you can see
The Medicaid base payment was lower than Medicare for all 18 MS-DRGs that we looked at. At this point we applied the supplemental payment and provider contributions adjustments from the payment index scenarios that I mentioned earlier, and we used Scenario 4 to get to the net payment amount.

Applying those assumptions, we found that Medicaid net payments at the national level were about 6 percent higher than Medicare, and this result is similar to results from the American Hospital Association survey that has shown that Medicaid has a higher payment-to-cost ratio than Medicare since 2010.

Of course, you know, this doesn't apply across all of the 18 MS-DRGs we looked at. You can see here I've layered on the Medicaid base payment amount -- the net payment amount on top of the graph that I showed earlier for the base payment, and here two MS-DRGs were still -- Medicaid was still lower on two MS-DRGs than Medicare. But on 16 they were higher.

So from this analysis, we found a few key takeaways. First, Medicaid inpatient hospital payment varies widely both across states and within a state.
Overall, Medicaid net payment is comparable or higher than Medicare.

There were substantial challenges in doing this analysis, and it demonstrates how complicated it can be to calculate Medicaid payment for inpatient services and make comparisons to other states and benchmarks. You know, one of the main challenges is due to the supplemental payments and the financing, and that challenges our ability in any subsequent analysis to link payment to other measures such as access, quality, and value.

It also confirms the Commission's prior statements on the need for additional payment on financing and supplemental payment at the provider level, so we can do a better assessment of how individual providers are being paid and not have to make as many assumptions.

So at this point we would appreciate any comments from the Commission on the results of this analysis and any potential areas for additional work. We’d also appreciate any thoughts you have on how we may disseminate this information. It could be a stand-alone document or included in one of MACPAC’s future reports to Congress.

CHAIR ROSENBAUM: Thank you, Chris.
I wonder if I could ask Sheldon to lead us off and then followed by Toby, Andy, Stacey. Alan is not here yet. Okay.

COMMISSIONER RETCHIN: Thanks, Sara. Great job, Chris. I really appreciate the analysis.

You know, while you were going through this -- and, actually, in observations previously -- it's an interesting conclusion that I come to when I compare hospital and physician payments. So let me just ask if you think this is true as I go through this, because one of the references or citations in this was with Zuckerman's analysis of physician payment, when in fact that was really an analysis of primary care only.

Prior to that, Zuckerman had looked at physician fees across specialties, across states on Medicaid. So the observation I would make, assuming the analysis holds true, is that Medicaid, as a matter of policy, pays more than Medicare for hospitals. Is that a conclusion I can draw? When you take into account all -- the supplemental payments that we can measure.

MR. PARK: Based on the analysis so far, given
all the assumptions we've made, it does look like for inpatient hospital services, Medicaid does pay higher than Medicare, kind of at the national level. Of course --

COMMISSIONER RETCHIN: There are a lot of variations, and there are caveats to that.

MR. PARK: Yes.

COMMISSIONER RETCHIN: Flip that around, and actually, this should ring true for the other Commissioners, that Medicare pays higher for physician services or provider services than Medicaid.

MR. PARK: That appears to be the case based on the Zuckerman study.

COMMISSIONER RETCHIN: And that's why I keep coming back to this. For the Medicaid population, it would be difficult, if not impossible, to achieve an adequate physician workforce for the Medicaid population, unless there was something else going on, whether the physicians are employed or they're in some way able to make up the difference through other arrangements. And that's what I think is missing when we analyze this. Anyway, it's just an observation.

Other than that, I do think when you're comparing
MS-DRGs -- we discussed this -- it gets a little difficult across different payers like Medicaid and Medicare where you're dealing with such different populations, albeit you tried by eliminating some of those that would contaminate the analysis. Whereas, with physician fees that are largely E&M, those are pretty comparable. So it's just an observation.

CHAIR ROSENBAUM: Can I just ask, Sheldon, are you suggesting that one thing we might want to know more about is how Medicaid hospitals use the revenues they receive compared to hospitals when they're billing for Medicare patients? When hospitals are billing for Medicaid patients, they may take on a greater range of activities or scope of activities with what they do as hospitals versus what they might be doing for the Medicare patients?

COMMISSIONER RETCHIN: And I keep coming back to this. I don't know how we would analyze that other than case studies, but I think it's undeniable, and from that I see in the marketplace, it would be -- when you're looking at payment rates for physician that -- average in California at one time, it was less than 60 percent of Medicare. It would be virtually impossible for them to --
inadequate workforce. So, yeah, I am suggesting that's a very important observation from a policy standpoint.

CHAIR ROSENBAUM: Toby.

COMMISSIONER DOUGLAS: First of all, great analysis. It's just really, really useful information. Just building on some of the points you made, I definitely think we need to understand more at the provider level, what's going on. There's no question that this gives us a good sense on the aggregate across states and in a state, but just understanding what's going on among hospitals. And I know that's so difficult, but it's something we always have to keep in account.

The other, I would build on what Sheldon said. I think the point that the rates are at or above Medicare on average, comparing that, doing some type of analysis that looks at the physician side, and brings these two analyses together to raise questions, what are we seeing in states on investment in hospital versus physician services? What policies are potential to deal with the fact that we're all trying to reorganize care? And whether it's through investments or financing incentives that look at the fact that one state that might be at 110 percent of Medicare on
inpatient is at 60 or 70 percent of Medicare on physician services, and are there ways to assess that or at least bring it together? So we're seeing that.

The only other question I have -- and this is more just from a Medicaid policy. The upper payment limit is supposed to be Medicare for hospitals. So what is going on here is just an interesting question. Penny would be coming to me and saying, "What's going on here?"

[Laughter.]

COMMISSIONER DOUGLAS: So I'll leave it at that.

MR. PARK: Yeah. Just to address that last point, the upper payment limit is based on Medicare payment principles and not necessarily what Medicare would have necessarily paid at that particular point in time. So there could be some areas where a state may be used, like a cost-based Medicare payment methodology. There are different ways to calculate the UPL, and it's not exactly the payment.

COMMISSIONER DOUGLAS: I think we might need to put something like that in the paper, just to make that clear --

MR. PARK: Okay.
COMMISSIONER DOUGLAS: -- so we don't have --
that it doesn't cause a lot of problems with the underlying
policy. It's not that CMS or states are disregarding the
policy, but we need to understand what goes underneath
that.

CHAIR ROSENBAUM: Andy.

COMMISSIONER COHEN: Really interesting work.

Thank you for a great analysis.

I wanted to ask a question to make sure that I'm
understanding something correctly and then maybe just go
back to the big-picture point -- two points that have
already been raised.

So the question is this. On the Slide 24, that
shows Medicaid net payment for MS-DRGs. I guess I'm a
little confused about how you can talk about net payment
for a DRG because I thought the whole issue here is that
you have base payments that are per something, service day,
something like that, person stay, admission, discharge,
whatever, and then you have supplemental payments that are
not necessarily connected to service, stay, discharge,
admission, whatever it is. And so how you do -- and I just
want to make sure I understand. Presumably, this was a
calculation, but it doesn't actually reflect that there is -- you can't have a net payment that includes supplemental payments per, say, using the standard of an MS-DRG.

MR. PARK: That's correct.

COMMISSIONER COHEN: Okay.

MR. PARK: You have pointed out a lot of the limitations of what we've been able to do so far because we are using state-level data to make these factors that, as we've seen, payment can vary by hospital. It can vary by MS-DRG. We're applying the same factors equally to each hospital and to each Stay, and so you're right in that this may not show the true variation on net payment based on how -- like a particular hospital may choose to distribute the funds they receive in supplemental payments.

COMMISSIONER COHEN: It is interesting. I mean, there has obviously been discussion and rhetoric about the issue of Medicaid payment to different kinds of providers for years, and this is like a tremendous contribution to that discussion, a fact-based contribution to that discussion.

But I think I just want to say some sort interpretative things and restate what some other people
have been saying. What this tells us is how much Medicaid across states in the aggregate is paying to an industry compared to Medicare. It is not suggesting that every time a Medicaid payment goes to any given hospital in any given place that that payment is higher than if that patient had been a Medicare beneficiary. We really have -- we have no idea, and in fact, the only thing we know for sure, relatively for sure, is that in many -- actually, most states, the actual payment that goes along with that particular district, whatever you want to call it, admission is less than what they would have gotten for Medicare. It's the supplemental payments that makes a huge difference, but we have no idea what the -- we know little about what the distribution is of those things. So you just have to make sure that we're interpreting this about sort of payment to an industry as opposed to making some assumptions about what a particular hospital is receiving associated with any particular patient and payer mix. So that's one thing that I just want to say interpretively.

And I think the other point that Sheldon has raised and just sort of goes to the complication of all of this -- so we know about what we pay for an industry as
compared to Medicare. We certainly don't know that
Medicare gets it right necessarily in terms of like how
resources should be allocated across outpatient, inpatient,
different kinds of things. But we do know that Medicaid
varies from -- higher for inpatient, higher in the
aggregate in terms of total use of resources for inpatient,
lower for outpatient. And that's important for us to think
about, considering where the whole trend in population
health and the need to address costs where hospitalizations
are often a very high cost. We still see that overall,
incentives are sort of higher for use of inpatient services
in Medicaid, or they're paid a little bit better relatively
than outpatient. I think that's an important insight that
we need to think about.

But the other thing is that now, of course, many
hospitals are actually now systems that provide a lot of
outpatient care, too, and do cross-subsidization within
their own system. So whatever they're bringing in on the
inpatient side, they may be cross-subsidizing within their
own system, outpatient, for it. So we just have to sort of
remember that our world is not clean. We don't have
entities that only do -- we have very few entities that
only do an inpatient business anymore, and a lot of the blending of payment and other things happens within a system. And that's obviously very complicating because, changing payment on inpatient, for example, may end up having a very different -- you know, once it goes through a set of decisions inside a system, for example, the implications might be a reduction in outpatient services.

CHAIR ROSENBAUM: Thank you. Thank you. Stacey?

COMMISSIONER LAMPKIN: So thank you. I want to say this is a remarkable start to adding a significant amount to our knowledge base, and it's hard to do too. As somebody who dipped my toe in trying to do something like this on a much smaller scale a few years ago, the technical challenges are not trivial with trying to make this comparison. So I want to thank the team for that.

The biggest takeaway from this is how challenging it is that we cannot get supplemental payment information at a provider level. It's out there. I know I'm not the first. I'm speaking to the choir, but it just really is a critical thing that we need to try to complete this picture.

We also need to include managed care perspective,
as soon as that's practical, with good idea.

I would like to see us move to something we could publish on this. I think we have to be careful about what we say, and some of what we're doing is great for illustrating the problem with not being able to get the supplemental data at the individual level, but we need not to overreach in what we can say.

So, in particular, I was a little concerned about this graph right here, in fact, in taking the base payment comparison up to a supplemental or a net supplemental, just because of the allocation and the difference in case mix at the facility level that could skew something like this, because we're taking a fairly narrow picture, as I understand it, of disabled adult inpatient stays where we have both high Medicaid and Medicare utilization and focusing in on that, which may skew our facility mix a little bit.

The other thing I wondered, Chris, is -- and, again, related to what we can compare fairly to Medicare. Is there something we can use that as a baseline to be able to say about obstetric or pediatric care, which is a lot of the core population where we can't maybe fairly benchmark
it to Medicare? But if we have a baseline to Medicare, can we then show, relative to that baseline, how states are paying in these other areas? And I don't know the answer to the question. I just think it would be helpful in our big-picture understanding of how the hospitals are paid, if we can get to something like that.

MR. PARK: Yeah. I think we might be able to do something using the relative weights that CMS has created for the MS-DRGs. So that even though there might not be a lot of payment information on deliveries in Medicare, we could see that relative weight compared to kind of the average MS-DRG payment and extrapolate to what a payment would be for delivery under the MS-DRG system.

COMMISSIONER LAMPKIN: I think that would be helpful.

Then my last comment on this, as we move to something that we would publish, if we can identify states at least in appendices -- I understand the point of the blinding here was illustrative, but I think it pairs very nicely with the material that we've published on the state-specific inpatient payment methodologies and to be able to put those two side by side. Great contribution, so thank
you.

CHAIR ROSENBAUM: Marsha.

I wonder whether Alan might want to get settled. Are you set to talk? We had you down as maybe wanting to weigh in on this.

COMMISSIONER WEIL: Yes. Thank you. But, actually, I love the data, and I love the points that have been made, and I think I mostly want to echo Stacey's last point, which is that this is incredibly difficult. The contribution here is tremendous, but there are a lot of limitations that we just have to be really careful of as we move forward. So I'll leave it there. Thank you.

CHAIR ROSENBAUM: Marsha.

VICE CHAIR GOLD: Yeah. Hi. Great discussion.

Great work.

I had also some related to points I've heard, but in terms of putting out the material and thinking about some of the comments, one, it would be useful if there's a way to do it to get a sense of what share of either Medicaid inpatient admissions or revenue or something is included in this analysis, because it excludes managed care. And, in some states, that could be quite a bit,
although a lot of times, the SSI and things are not in it. So, probably, compared to people, it's a larger share of inpatient admissions is picked up in your analysis, but if there's some way to get a sense of how important this is vis-a-vis what we can't see.

Second, on the outpatient point that Andy brought up as well and others, I think that's really key in terms of dealing with some of Sheldon's concerns and others concerns, because it isn't just you have a physician office and you have an inpatient hospital. Increasingly, there's a lot of -- and for Medicaid always, there's always been a lot of outpatient care that's billed through the hospital, and it would be useful to understand if some of the differences carried over or not to the outpatient area than others. If they do, it gives an incentive for the hospital to internalize physician functions and adds to cost.

So I think if we're comparing physicians and hospitals, we have to really build in the fact that we don't cover -- and it's important to cover -- the share that is outpatient that occurs through the hospital and is billed through the hospital and the incentives there.

And the third ting, which is really just a
question, you have allocated all the extra payments to the inpatient side, I think. Does that mean we've overstated that it potentially overstates Medicaid payments relative to Medicare, or are these really inpatient payments, not total hospital payments?

MR. PARK: So the CMS 64 data that we use does have the ability for states to report inpatient supplemental payments versus outpatient supplemental payments. Most states say the majority of their supplemental payments in hospitals are for inpatient services.

To Andy's point, once it gets to the hospital, we don't know how they use the dollars.

VICE CHAIR GOLD: But they're reported as inpatient.

MR. PARK: Yes.

CHAIR ROSENBAUM: Good. Kit, and then Penny and then Brian.

COMMISSIONER GORTON: So just quickly echoing what everybody else has said, I think this is important work. I do think we should move forward to reporting it somehow, and I agree with the folks who have said that at
that point we should probably unmask it, because I think it's important data for state decisionmakers to know where they stand and be able to benchmark themselves against others. They may continue to make the choices that they're making, but we ought to at least help them make informed choices.

A couple of things, sort of following up on what Marsha was saying about managed care. I do think you need to figure out some way to adjust some of these data for managed care impact. If we go back to the distribution graph on Slide 8, Connecticut it looks to me is sitting at about 0.85, Massachusetts at about 1.05, and Rhode Island in the middle at about 0.95. We know we've seen data from other sources that suggests that Rhode Island is a higher payer.

What I would say to you is Connecticut has no Medicaid managed care based on a policy decision that the current administration made. Massachusetts actually has about 50 percent. And Rhode Island has bet the farm on managed care, and about 90 percent of their Medicaid population -- and it's a growing percentage -- is in managed care.
I think it's a generally accepted observation that the managed care plans often have to -- always have to pay at least what Medicaid, the state agencies, are paying and often have to pay some inflator on top of that. So by missing the amount of care that's delivered in the managed care setting -- I mean, I think if you took Rhode Island and said, okay, pick a number, the plans are paying 105 to 110 percent of state Medicaid, but 90 percent of the care is -- I think on your index, Rhode Island goes up a bit. And so I do think you need to figure out a way to model an adjustment for that -- I guess building on what Marsha was saying -- that allows you to figure out effectively what the state is paying across all of its payment methodologies.

VICE CHAIR GOLD: I don't know how feasible that is because managed care data [off microphone] --

COMMISSIONER GORTON: I'm not suggesting you build it off of managed care data. I'm suggesting that what you do is you come up with some adjustment, which I think would be rough, that says that you need to assess Rhode Island differently from Connecticut and you figure out how to weight that. You know, I'm not an actuary, I've
never played one on TV, but I do think that we want to think about that. And I think at the very least it needs to be spoken to, and that gets me to my second point, which is that I do think there's an opportunity to do some qualitative and descriptive work about how the plans in the current state are paying their hospital providers, everything from quality incentives to percent of premium deals to shared savings arrangements. You know, CMS has been pushing hard over the last 5 years to try and move people in the direction of alternative payment methodologies. Most states do collect data from the plans about what percentage of their networks, you know, are in alternative payment methodologies. Massachusetts and some other states actually publish those data. CHIA has just put them out for Massachusetts in the last month. And so I do think it's worth talking about how states may, in fact, use the managed care programs to push money out and to shape care. And the final point is to what Andy was saying, which is sometimes there are trade-offs. Sometimes we might decide to feather back funding on inpatient in order...
to push funding out to primary care or to push -- you know, a big push, can we push funding out to behavioral health? And so I do think there's room, in addition to these data, which are very important and should be put out there, to do some really fairly high quality descriptive work that sort of sets it...

CHAIR ROSENBAUM: Before going to Penny and Brian, can I just note the importance of what you raised about the managed care payment policies -- and I do not want to take time on it now -- but any thoughts you have on how we might get those data, because they are treated as proprietary.

COMMISSIONER GORTON: Sure, I'm happy to take it offline. But there are some ways that one could get data that would be informative.

CHAIR ROSENBAUM: Okay.

COMMISSIONER THOMPSON: I'll be quick because I know we're at the end of this. This is fantastic and great conversation.

I just wanted to sort of follow up on this question about the supplementals and then the net payments. One is appreciating on the supplementals. Part of this
makes me wonder whether or not we do have enough data here to really publish an analysis that's meaningful if we're missing almost 50 percent of the dollars that are being paid out under fee-for-service because of the supplementals and how we could address that.

The other point is sort of similar to what Andy raised, which is it's my belief that the payment of the supplementals is highly variable in the class that we're looking at. And so the impact of that, we've sort of spread it out across an entire group of payments, and it probably doesn't really look that way and probably doesn't even closely look that way.

And then the other point is just asking you, Chris, about this calculation of a net payment, which is taking off provider contributions and just -- we'll probably get in this later today. I just want to understand the thinking behind that, which is that's a cost to providers, but there are lots of costs to providers. And so can you just say a little bit about why you think that measure is meaningful?

MR. PARK: Sure. I think one reason is that when we're making the supplemental payment adjustment, we're
adding in a substantial amount of dollars, and a lot of
those supplemental payments are specifically tied to, as a
class, the hospitals contributing some of that money. And
so if we make that supplemental payment adjustment without
taking into account that those payments would probably not
have happened unless the hospitals contributed a portion of
that money, I think we would be overflating the impact of
the supplemental payments for the providers’ net inpatient
revenue because -- and if those costs are specifically tied
to, you know, the payment that they ultimately receive in
supplemental payments, where other costs are kind of spread
across payers, you know, there's allocation going on, but, you
know, it doesn't -- you know, one particular hospital
under like a DRG payment system has higher costs for plant,
the building and rent and stuff like that, that doesn't
necessarily mean that their Medicaid payment is going to be
higher. But in this case, there is a more direct link
between the amount the provider contributed and -- you
know, if they didn't contribute any of that money, they
might not get a supplemental payment in aggregate.

COMMISSIONER THOMPSON: Right. Well, I don't
want to go down this rabbit hole here. I mean, we'll
probably go down this rabbit hole later today. But I would
put a pin in that question because, of course, by law they
cannot be tied.

    MR. PARK: Yes.

    COMMISSIONER THOMPSON: And so I just want to be
-- you know, there is certainly -- without revenue, you
don't create the program, but that doesn't mean that the
revenue and the program are completely one-to-one.

    MR. PARK: That is correct.

    COMMISSIONER THOMPSON: Okay.

    COMMISSIONER DOUGLAS: Can I follow up on that?

We can talk about -- I'm really glad, Penny, you raised
this, and I have to say that the more I think about it, I'm
very concerned about using this net. I think we really
need to think it through, because I think it's actually
making a policy judgment and the underlining principles of
Medicaid financing.

    CHAIR ROSENBAUM: [off microphone] an attribution
that may not exist.

    COMMISSIONER DOUGLAS: Well, yeah, isn't that
what we're saying, is it's not -- in certain ways it gets
to the question is that a legit -- non-federal share.
COMMISSIONER BURWELL: So a clarification question. On the Medicaid side, we chose to select the Medicaid disabled population only.

MR. PARK: Yes.

COMMISSIONER BURWELL: On the Medicare side, do we use the entire Medicare population or just the disabled population?

MR. PARK: We use the entire Medicare population. The data we have was aggregated at the hospital and MS-DRG level, so we did not have the ability to make any population adjustments on that side.

COMMISSIONER BURWELL: Do you think that might make any difference?

MR. PARK: I think it could make a difference, but because we're looking at specific MS-DRGs and conditions, I think that does reduce a lot of the variability that might occur on the population if you have, you know, like a coronary artery bypass graft, you know, that in itself kind of equalizes the population somewhat because they have the same condition and are receiving similar services. And so I think whether you're disabled or non-disabled at that point is a secondary factor, you
know, in terms of looking at the payment for that particular service versus the condition you actually have.

COMMISSIONER BURWELL: My second question relates to Table 2, which is the differences in the index across types of DRGs within a state.

MR. PARK: Yes.

COMMISSIONER BURWELL: I just find that data perplexing, how a state can vary so much dramatically from condition -- you would think that Medicaid payment to hospitals would be relatively consistent across conditions, but this table suggests that it is not.

MR. PARK: Yeah, and, again, I think this points out the complexity, particularly with like inpatient payment, because, one, states may have made specific policy decisions to pay higher for one service or lower for another. And so instead of using a standard DRG weighting system, they've tweaked it a little bit so that -- you know, like I said, states want to discourage the use of early elective cesarean sections, and so they're going to pay that closer to vaginal delivery as a policy choice to try to discourage that. So there's one case where, you know, the payment for a level of three different services
may be different. The other is, you know, as we showed, the range of payment across hospitals may vary within the state because of the way they make the payment, if it's cost-based or per diem or average per stay or anything like that, you know, that gets into, okay, what is the exact mix of hospitals, you know, within that state for that particular time period that you're analyzing. And, you know, if you like looked at, you know, for whatever reason that year, the fee-for-service data that we had had like a very high mix of hospitals that were paid on a cost basis, then that might make that state look -- you know, depending on what services those particular hospitals provided, that might make their average payment for those services higher than what you see for others.

COMMISSIONER BURWELL: Okay. I'd just like to echo what everybody else is saying. This is an extremely fruitful path of analysis and what's missing seems to be -- is improved data. I'm a little concerned that the data are 2010 MAX data. So I would just encourage trying to fill -- pursue this analysis and try to fill in where we can on better data sources.

MR. PARK: Certainly. I think at this point, you
know, we could probably update this to 2012 because I think most of the states have submitted 2012 data. But, again, at this point we wanted to present the results first, and then if you feel like we should update to a more recent year, then we could do that.

CHAIR ROSENBAUM: Alan, we'll give you the last question because we are well over time.

COMMISSIONER WEIL: So what I want to do is sort of make a comment on the comments because I didn't have much of a comment initially.

I want us to think about the limitations and sort of have the humility to understand that no matter how much we dig into a lot of these things, the limitations are going to in some ways overshadow what's doable. And so I want to think about what we can do and try to -- the netting-out conversation led me to want to make this comment.

I think the analysis is really interesting at the aggregate level, the comment about, you know, are we over - - is it more than Medicare. I think state base payment rates are important state policy statements, and they are worth knowing and describing, even if there's a lot of
supplemental payments, even if there's a lot of managed care. I still think how states pay is important information and what those levels are is important.

Anything beyond that is going to be very hard to tease out what's happening inside the institution, what's happening inside managed care, what's happen -- how do you appropriately allocate to individual DRGs.

The one item I do think we have to really grapple with is this -- really the policy question of netting out provider contributions, because that changes the whole scale of what the top-line finding is about whether -- you know, what the aggregate sense of Medicaid payment rates are.

And so I think that one is different, but a lot of these others are nice to know, and believe me, I'd love to know them, too. But I think ultimately we have to acknowledge that no matter how much we try to go behind this, the caveats are always going to be extensive, and so we should focus on what are the things we need to understand better to have the right top-line conclusion.

CHAIR ROSENBAUM: Thank you very much, Chris.

All right. We're going to move right into the
next presentation, DSH.

### IMPLICATIONS OF ACA COVERAGE EXPANSIONS FOR 
MEDICAID DSH POLICY

* MR. NELB: Okay. Thank you, Sara.

So I am going to continue our discussion of hospital payments by sharing some of our latest work on disproportionate share hospital payments with you today. I am the one presenting, but I just want to acknowledge the contributions of the team that helped pull all this data together, including my colleagues, Kacey and Madeline at MACPAC, and our contractors, Dobson DaVanzo and KNG Health. It's a team effort to pull all this together.

Okay. So, today, I'm going to begin, as always, with a brief background on Medicaid DSH payments and then focus the time on sharing some of our preliminary findings on the effects of the ACA on hospital uncompensated care.

I will then look at how these changes in uncompensated care relate to pending DSH allotment reductions, and then discuss the implications of these findings for the targeting of Medicaid DSH payments at the state and provider level.

Overall, we're finding that ACA coverage
expansions are having very different effects in states that have expanded Medicaid and those that haven't, which raises a variety of policy questions for the Commission to consider about whether and how state Medicaid expansion decisions should affect the targeting of DSH payments.

So, for a quick refresher on Medicaid DSH, in 2014 states made a total of $18 billion in Medicaid DSH payments to about half of all U.S. hospitals, which helps offset those hospitals' costs of uncompensated care for both Medicaid patients and the uninsured.

States have considerable flexibility to determine which hospitals in their state receive DSH payments, but they're statutorily required to make DSH payments to hospitals that serve a high share of Medicaid and low-income payments, which are known as deemed DSH hospitals, and they're about 10 to 15 percent of all U.S. hospitals.

In addition, total DSH payments are limited by federal DSH allotments, which are currently scheduled to be reduced in fiscal year 2018, which begins in September of next year. The amount of the reductions begins at $2 billion, a 16 percent reduction in 2018, and then will increase each year up to 2025, when there's an $8 billion
reduction, which is about a 55 percent cut. As background, I also just want to point out that Medicare also makes DSH payments to hospitals, which have the same name and acronym but are based on a totally different formula. In 2014, the ACA changed the way that Medicare DSH payments were calculated and in particular created a new Medicare uncompensated care pool that is tied to the number of uninsured nationally.

Although Medicaid DSH cuts have been delayed, Medicare DSH cuts did take effect, as scheduled under the ACA, and so far, Medicare DSH payments have been reduced by about $3 billion.

As part of one of the pieces of legislation that delayed the Medicaid DSH cuts, Congress required MACPAC to report annually on Medicaid DSH payments and their relationship to a variety of factors listed here. MACPAC's first DSH report was published in February of this year, and next year, these data will be included in the Commission's March report to Congress.

In our first report, we primarily examined hospital uncompensated care in 2013 using some of the data that was available at the time. However, now new data are
available about the effects of the ACA on hospital uncompensated care.

To preview some of the new data that are available, this slide summarizes some of our preliminary findings about the effects of the ACA on uncompensated care.

Between 2013 and 2014, we found that hospital uncompensated care fell by about $4.9 billion in states that have expanded Medicaid. Although there was some increase in Medicaid shortfall, it was offset by larger declines in both charity care and bad debt. However, in states that have not expanded Medicaid, we're not seeing similar improvements. In hospital uncompensated care, there was actually a slight increase.

Finally, although this decline in uncompensated care has improved hospital margins by about 1 percentage point between 2013 and 2014, we're finding that the deemed DSH hospitals, those that serve the highest share of Medicaid and low-income patients, are still reporting large and negative operating margins in both expansion and non-expansion states.

This figure compares the percent decline in the
number of uninsured and the decline in uncompensated care as a share of operating cost for hospitals in both expansion and non-expansion states. So, in this figure, larger bars indicate a larger decline between 2013 and 2014.

In Medicaid expansion states, we found that there was a larger decline -- there was a large decline in the number of uninsured that was accompanied by an even larger decline in uncompensated care. However, in non-expansion states, even though there was some decline in the number uninsured, it didn't seem to be accompanied by a similar decline in uncompensated care for the uninsured.

Using some of this new uncompensated care data, we developed a model to project hospital uncompensated care costs in relation to pending DSH allotment reductions, since DSH reductions are premised in part on the assumption that ACA coverage expansions would reduce hospital uncompensated care.

Our preliminary estimates, which I want to emphasize are still preliminary, suggest that when the full Medicaid DSH allotment reduction take effect in 2025, hospital uncompensated care will be about $21.7 billion
lower than it would have been without the ACA.

This figure displays some of the preliminary findings from our model for all hospitals at the national level. The dark blue line in the middle shows projected charity care and bad debt costs for the uninsured, and the light blue line on top shows our projections for total uncompensated care as defined for Medicaid DSH purposes, which includes Medicaid shortfall.

The bar at the bottom of the chart show Medicaid DSH allotments, with the solid bars showing federal DSH funds and the hollow bars on top showing the state's share of Medicaid DSH funding. We're showing the status quo scenario with federal DSH allotment reductions beginning in 2018 and increasing each year until 2025.

Overall, we see that uncompensated care is expected to continue to fall as ACA coverage expansions take full effect, but Medicaid DSH funding is still projected to be less than total hospital uncompensated care in the aggregate.

In your materials, we have some additional information about our projections of uncompensated care for expansion and non-expansion states. As I discussed
earlier, virtually all of the reductions in uncompensated
care is occurring in expansion states, so these charts look
very different for the two subsets of states.

Our modeling raises several questions about how
DSH allotment reductions should be targeted at the state
level. Under the allotment reduction that CMS initially
proposed for DSH allotment reductions, Medicaid expansion
states are expected to have larger reductions than states
that have not expanded Medicaid, since the formula bases
one-third of the reductions on the number of uninsured in
the state, which is related to whether states expanded
Medicaid.

In your materials, we present some preliminary
analysis of the effects of changing the relative weights of
this formula in order to apply larger or smaller reductions
to states that have expanded Medicaid.

However, in order to evaluate any of these
options or others that the Commission would like to
consider, the Commission will need to think about the
question about whether and how state Medicaid expansion
decisions should affect state DSH allotments.

In addition to looking at targeting at the state
level, our analysis also has implications for the targeting of DSH payments at the provider level. For example, the Commission has previously discussed the possibility of raising the minimum eligibility threshold for DSH payments above the current level, which is a 1 percent Medicaid utilization rate. However, as the Commission considers what alternative thresholds might be appropriate, it's important to be aware that states and hospitals that have expanded Medicaid have higher Medicaid utilization rates.

Within states, however, we continue to find that the deemed DSH hospitals serve a higher share of Medicaid in low-income patients and also have higher levels of uncompensated care when we look at levels relative to other hospitals in the state.

In addition, there may be some measures, such as the low-income utilization rate, which is based on both Medicaid and uninsured patients and seems to be less affected by state Medicaid expansion decisions.

This final chart just illustrates, again, the differences in uncompensated care that we're seeing between expansion and non-expansion states in 2014. We found that, rather surprisingly, DSH hospitals in Medicaid expansion
states now have less uncompensated care than non-DSH hospitals in states that have not expanded Medicaid. However, within each state, again, these deemed DSH hospitals, the one that served the highest share of Medicaid and low-income patients, have more uncompensated care than others in their state.

That concludes my presentation today. Here are some policy questions you may want to consider, and I'm happy to answer any questions that you might have, but mostly, I'll try to be a good listener and incorporate your feedback into our future work on this issue.

Thanks.

CHAIR ROSENBAUM: So, Sheldon, would you like to lead us off again?

COMMISSIONER RETCHIN: Yeah. Thanks. This is kind of my morning.

So this is great work, and I continue to think that the analysis on the supplemental payments, specifically to DSH, has important contributions and is important policy as we make our way towards October and some major policy implications with the reductions in DSH.

As I read it, it sort of confirmed what I had
thought, and it's that the expansion states and the non-
expansion states from the get-go were and are very
different, just in terms of the DNA, the way that they
funded the vulnerable populations in Medicaid and the
number of those individuals in those states. Those states
just happen to be different, and the hospitals within are
different.

As I read it as well, post-expansion, it struck
me that those hospitals that are deemed DSH hospitals or
those hospitals that were reliant on supplemental income
before expansion continued to be reliant, with the
expansion, they would say, "We are getting better and
feeling worse."

There are only so many conclusions you can make
after this. Why are these hospitals still struggling
financially? And I do want to get back to one table on
that.

I am sure there are other explanations, but one
is that the supplemental income, in this case, DSH, is
being used in some of those states or many of those states
in a different way than we might suggest, and that's why we
continue to focus on targeting. That seems like a very
There could be a moral hazard that with expansion, some of these hospitals have been flooded with patients who are Medicaid and altered the payer mix in those hospitals that are deemed DSH hospitals or those hospitals that happen to take care of these patients, because, let's face it, when it comes to government-sponsored care, Medicare and Medicaid, hospitals that make margins in those payers have negative overall margins; that is, almost all hospitals still cost-shift in using commercial payers. Those that don't aren't making money overall.

Or is it that these hospitals are just inefficient and ineffective, they don't have the infrastructure from before, or is there a difference in beneficiaries? I continue to go back that it's in the way DSH is being used and would like to propose that in some way or another, the Commission makes specific or explicit recommendations on the allocation of DSH with an allocation of DSH cuts.

Before I pass this along, I just wanted to go back to one table, Rob, which is Figure 9 on page 19. I am
still bothered by the last column that hospitals -- these
are safety net hospitals, we're all familiar with, who have
a negative operating margin of almost 6 percent. After
DSH, still have a negative margin of 2.8, 3 percent, but
somehow, after that, from other income are able to bounce
up to 6.3 percent. It just doesn't ring true for me. It
can't be from earnings off of their balance sheets. It
just can't be. And maybe local communities are
supplementing these hospitals, but to the tune of a 6.3
percent total margin just doesn't ring true.

CHAIR ROSENBAUM: Okay. Stacey.

COMMISSIONER LAMPKIN: So thanks, a lot of great
stuff here.

I read this, and I feel like we need a theory of
everything, and I want to explain. Really, I do think we
need a theory of everything. It feels like we're being
asked for nothing less than what is the role and purpose of
DSH in the new world, and that's the question here. And
then it doesn't take much to think, well, I need to
understand how to think about adequate Medicaid payments
and where does Medicaid shortfall belong and what is the
right mechanisms to pay hospitals adequately for the
services provided to Medicaid recipients, and should that
have anything to do with DSH? And so I really feel like I
am reaching to tie several of these linked things that
we'll talk about today together before we can really know
where to go specifically on DSH allocations, which feel so
-- not mundane, but technical in light of the broader
question. So that's kind of where I get stumped on here.

I'll just make a couple of specific comments
about the material you've presented as well. I think that
the explanation of the interaction between the Medicaid
shortfall and uncompensated care and expansion states and
non-expansion states was enormously helpful, and that's
great information for people to understand how that works
and how that works together.

The projections and the graphs you put together
on the projections, outstanding, intuitive way to
understand the information presented.

I, too, struggled with the operating margins in
the quartile exhibits. I either need different graphics or
help in the narrative understanding what the operating
margins mean and how I'm supposed to relate them to the DSH
questions and what conclusions to draw. So I think that
area could use a little bit, but very helpful information. Thank you.

CHAIR ROSENBAUM: Alan.

COMMISSIONER WEIL: So I'm once again with Stacey. I think you need theory of everything. What I liked about this is it gave me the opportunity to pretend I'm a member of the Supreme Court writing NFIB v. Sebelius, because, in essence, what you're asking -- I mean, the question that's been presented is, How do you handle a slice this big in a context that is not the one that the people who wrote it thought it was going to be? So I took a cut at it, and we'll see if it's of any interest to anyone else.

So I start with DSH was designed to provide hospitals with money, and like many other things in Medicaid, states have a lot of flexibility under the statute in how they define and distribute, other than the basic standards that you've mentioned. And I also -- maybe, Sara, you and I have been talking too much over the years, but I always want to remind people, DSH is a Medicaid expenditure made by the state and by the federal government. It's not different.
So here, we have the Affordable Care Act that reduces DSH payments based on what happily turned out to be the accurate assumption that when you expand Medicaid uncompensated care, it does down, which that might not have turned out to be so, but now we have really -- this is not the first. We've published in "Health Affairs." Also, it's very clear.

The question you asked that I focused on, because it's the one that I think is most -- the one that I can get my head around best is this question of should you treat states that expanded differently than those that you don't, and this is my way of thinking about it, for what it's worth. States' decision whether or not to expand Medicaid, although we didn't think it was going to be a choice, is now a choice, but it's one among many that states have the authority to make in Medicaid. And, particularly, another one that states get to make is what are their base hospital rates, and the notion that we would sort of penalize -- and I know you didn't use that word, but that's how a lot of people talk about it -- penalize states for their choice on the Medicaid expansion, but we never in DSH think about penalizing states for having low hospital payment rates,
which creates a similar problem, that seems like an odd
match to me.

Similarly, the politics and perception of how
real the state's share of DSH is, that's part of a bigger
issue that we're going to talk about more, but I think
that's a red herring because, once again, it would be
putting DSH in a different category than all the broader
questions about Medicaid, which I think is Stacey's point,
which is that to pull this out separately is a challenge.

And that then gets me to sort of the governance
problem, which is this is a program that provides resources
to hospitals to help them serve people, and while obviously
hospitals and people are in states and may lobby and
advocate for certain positions about Medicaid expansion, at
the end of the day, the decision-maker about Medicaid
expansion is the state government and not the hospitals or
the people they serve, and so to hold the hospitals or the
people they serve accountable or penalize them for that
decision also doesn't make sense to me.

So where I land is that while I think the merits
of the size of the DSH cuts in the ACA are certainly open
to question, given that not all states expand to Medicaid
and those cuts were based on that assumption, if we're going to focus solely on the question of the distribution of DSH dollars across states in the wake of this unexpected choice by states, I would stick to all of the same factors that we should be thinking about in DSH allocation, even without this provision, and not sort of carve out state Medicaid expansion decision as different from all the other state choices.

So I think there is a lot of merit in asking the question how should states allocate DSH dollars. How should they be matched? Should there be federal allocations to hospitals that go around states? I think those are all interesting and important questions, but if we're presented with sort of the -- it's not really very narrow, but if we're presented with a specific question of whether state allocation should be varied based on the state Medicaid expansion decision, even though I have views about what I would hope states would do, based on what DSH is designed to do and based on what Congress said about DSH or what we understand Congress' thinking, which is always a somewhat risky endeavor in the cuts and the ACA, I'd have a hard time putting that in there.
And then I would just -- since that was all focused on your one question and you asked others, I would align myself with both the high quality of the work and a few areas where I think there's additional clarification.

CHAIR ROSENBAUM: I have to say, which has been the issue on my mind all morning, that given the tools in the state agency's toolbox for steering around all kinds of, you know, Scylla and Charybdis situations, whether the Medicaid expansion decision ought to be viewed in isolation is really -- rises to me as a very important one. You know, there are just so many ways in which a state can counterbalance one set of decisions with another, particular where hospital payment is concerned.

I know you have to step out, and did you have a comment?

COMMISSIONER COHEN: Well, just to quickly say I agree with both Alan's analysis and his conclusion, and I just think that we really -- we should focus the question I mean, with some agreement, that better targeting of DSH as a possible area for our, you know, making a recommendation or taking some future action where, sort of, redesigning all Medicaid payment in the short term, by
December, probably not so much.

I would just say we need to focus on the purposes of DSH, which we've written about. It's about, you know, access to human beings and the financial stability of safety net hospitals, which we really don't have much of a definition of but we could help to generate one, and I do really think we have to be looking at what the situation of the specific hospitals is in terms of their -- the amount of uncompensated care that they're providing.

Now that only answers one question, which is the question that Alan also answered, the question of exactly what the, like -- what the targeting mechanism is is really complicated, and I would just say I think we do need -- so deemed DSH hospitals is like, it's exists. It's a standard that exists already but we don't really know anything about the distribution of hospitals around that standard. We know how many hospitals are in the deemed DSH -- you know, like heavy, intense DSH hospitals -- but we don't know whether there's a bunch that are right outside, or what the component, sort of, parts of it are.

So I think a little bit more analysis around sort of distribution under a number of different standards would
be very helpful and us, sort of -- if we decide to go down
this path, targeting the actual sort of hospital standards
that we want to use.

CHAIR ROSENBAUM: Toby, did you want to jump in?

COMMISSIONER DOUGLAS: No. I'm okay.

CHAIR ROSENBAUM: Let me see if we have a --

COMMISSIONER GORTON: So I would just build on
this theory of everything question, because I do think it's
important. And I guess the way I think about it is each of
the state health care delivery systems has a financial
ecology, and the federal government contributes a big slide
of what goes into that, state governments, and then the
employers and the commercial insurers, as well, and then in
states with heavy military presence you've got TRICARE and
-- I guess you'd call it -- that's federal but it's DoD so
it's different.

For me, the question -- the important question is
are those federal dollars being fairly and equitably
distributed across the state markets? And I think we have
some evidence that maybe they're not, and I think we have
some evidence that some states have been better at drawing
down those federal dollars than others. And I think that's
a relevant place to shine some light.

Now, some states have made, to Alan's point, a political, philosophical, and some of them frame it as a moral choice not to drive down federal dollars. So that's how Governor Jindal framed his non-participation in the Medicaid expansion. And whether or not I agree with that, we need to respect the state's opportunity to do those things.

So I guess for me the other big question here is the federalism question. I think we ought to be interested in whether or not federal funds for health care are being equitably distributed across states, and I think MACPAC has a role to play in looking at the Medicaid slices of that, and within Medicaid DSH, and, you know, you could throw in DSRIP and some of the other supplementals that go on.

But I don't think we should kid ourselves that Medicaid is necessarily the whole pie, and I don't think we should kid ourselves that at the federal level we have enough granularity of understanding of these individual state health care delivery systems to be able to do the allocation within the state programs. And we talked about it -- I won't rehearse it again. States have made a lot of
choices, and some of them are thoughtful and some of them are less thoughtful, and some of them we agree with and some of them we agree with and we still disagree with them. But they've made them. And I worry about us taking a very narrow sliver, which is DSH, and starting to pull on that thread without thinking about what unravels across the whole delivery system.

So as a health plan who negotiates with both the state customers and with the provider community, we do a lot of horse-trading. And so there's -- somebody was talking about cost-shifting and the cost-shifting is a big deal. Some of the state policy decisions are exclusively made with an eye towards that cost-shifting. And so I do think we need to worry about federalizing this and moving the governance of this to the federal level.

So I would be inclined to say we ought to figure out -- my point of view would be that MACPAC should think about making recommendations about equitable distribution of Medicaid funds, including DSH, but at the end of the day that the states should decide how they allocate it, because they have more insight into how their mental health and foster systems and all the other things work than at the
CHAIR ROSENBAUM: Well, and I would note that to the extent that we think about the question of what is equitable in the distribution of Medicaid funds we will see this afternoon that the loop sort of gets closed because then you have the question of what is equitable policy on where states -- the flexibility states should have to develop their expenditure policies.

And so this is where we've now, you know, sort of managed to attach all of the sessions into one bolus.

COMMISSIONER RETCHIN: You know, I'll just weigh back in on the -- and I realize DSH is a relatively small part of -- which was another part of the analysis, was illuminating.

I'll first of all call attention, on Figure 2, page 7, that the Medicaid payment-to-cost ratio estimates from differing methods have some variation. I do point out that regardless -- even if you took the AHA or the DSH audits, that if you have a growth in that segment of a provider's population, you're still dealing with 10 percent losses on this population.

But going back to Kit's point, there are states
that actually abdicate from the responsibility of allocating DSH. They abdicate it or transfer it to a third party, hospital associations, where the policies really are not reflected in terms of the population being served but rather than of the members.

And I also think that a policy that says that hospitals are eligible for DSH if they have 1 percent utilization rates, surely this will be corrected or amended in some way or another. But I would like to see us weigh in. We have data here. It's a relatively small amount that's being distributed but still it's folding money, and that maybe we could start to focus on that as a target.

CHAIR ROSENBAUM: Any other questions for Rob?

[No response.]

CHAIR ROSENBAUM: Seeing none, thank you so much. It was terrific.

And we now have time for public comment on the first two segments of this morning.

Thank you so much. If you could just identify yourself.

### PUBLIC COMMENT

* MS. GONTSCAROW: Hi. Good morning. Zina
Gontscharow with America's Essential Hospitals. Thank you very much for the opportunity to comment and for your continued focus on the issue of Medicaid DSH. We also thank you for your continued hard work on the annual DSH payment study and we are looking forward to its release.

Medicaid DSH is absolutely vital to Essential Hospitals across the country. Because of our commitment to care for the underserved, half of our patients are uninsured or Medicaid beneficiaries. Essentials Hospitals had an aggregate zero percent operating margin in 2014, following several years of negative margins. Without Medicaid DSH, their margins would have been an unsustainable, negative 6.21 percent.

As such, Essential Hospitals must have the financial resources they need to keep their doors open and provide services to all patients, particularly low-income and other vulnerable people. This is consistent with Congress' stated intent in the DSH statute.

As we look forward to the methodology for the impending DSH cuts, we urge better targeting to the hospitals that are truly serving the underserved, the uninsured, and the Medicaid beneficiaries.
We look forward to any opportunity to work with the Commission on this important topic.

Thank you.

CHAIR ROSENBAUM: Thank you.

Any other comments?

[No response.]

CHAIR ROSENBAUM: Yeah. Why don't we take a break and resume in about 10 minutes.

* [Recess.]

CHAIR ROSENBAUM: Why don't we reconvene in the next couple of minutes?

[Pause.]

CHAIR ROSENBAUM: All right. So we are back, and Kristal Vardaman is going to take us through the role of residential care settings in long-term services and supports.

### ROLE OF RESIDENTIAL CARE SETTINGS IN DELIVERING LONG-TERM SERVICES AND SUPPORTS

* MS. VARDAMAN: Great. Good morning, Commissioners. Again, I will be presenting on the role of residential care settings in serving Medicaid beneficiaries, and for the order of today's presentation,
I'm going to begin with some background on home and community-based services in residential care settings. I'll then go on to some findings from some work that RTI conducted for the Commission and then discuss some future work and potential policy questions for your discussion.

To start, home and community-based services have been promoted in recent years by states and the federal government through a variety of investments. Home and community-based services include services where providers come to a beneficiary's home, like personal care attendants that may help with activities of daily living. It also includes providers where the beneficiary is traveling to them, like day service providers. And it also includes residential care settings, which we'll discuss today, that integrate housing and care.

In fiscal year 2013, for the first time national Medicaid expenditures on home and community-based services exceeded institutional care, and based on more current data for 2014, that trend continued into 2014.

Residential care settings are community-based settings for individuals who cannot live completely independently. They have a variety of different
definitions and licensing by different states. It includes both small group homes as well as large assisted living communities. In addition to the size, residential care settings vary in the types of services they provide and the populations they serve. The most common services provided are personal care services. Fewer offer skilled nursing care. And also some focus on specific populations such as individuals with dementia.

Despite the progress that states and the federal government have had in rebalancing, there's current policies that provide some incentives for institutionalization rather than community settings, even when beneficiaries might be well served in a residential care setting. Some of these incentives include the fact that HCBS are optional while nursing facility services are a mandatory benefit. And as you know, states administer HCBS through waivers often which may have waiting lists which limit access to settings such as residential care settings.

Also, Medicaid pays for room and board at institutions but not for residential care settings or private homes, which is another disincentive for
As we began this work, we found that there were few studies that focused on residential care settings and how they serve Medicaid beneficiaries. And also there are a number of policy changes in the long-term services and supports landscape that may affect a beneficiary's access. So those were some motivations behind pursuing this work.

In addition, as we began pursuing this work, we found out that GAO had received a related request, and so there's some congressional interest in this as well.

I'd like to thank RTI International for their work and doing this for us. Their work involved three different tasks, which I'll go through today. First, they developed a compendium of Medicaid coverage and payment policies for all 50 states and the District of Columbia. Second, they conducted interviews with subject matter experts about policies that may affect beneficiaries' access to residential care settings. And finally, they conducted case studies of four states -- Colorado, Florida, North Carolina, and Washington. For those case studies, they did some more in-depth reviews of those states' coverage and payment policies as well as spoke with
stakeholders including state Medicaid staff, providers, and beneficiary advocates to get their perspectives on some of the policies that may influence access.

First I'll walk through some of the findings on the next few slides related to the compendium and their descriptions of Medicaid coverage and payment policies.

First, states can use several Medicaid authorities to cover services in residential care settings. Some of these are described in detail in the appendices in your briefing materials. They can use both waiver authorities as well as state plan authorities, and states may use different authorities in order to target residential care setting coverage to specific populations.

Also in the appendices in your materials is a large table that describes states -- authorities the states use to cover services in residential care settings as well as the related payment methodologies that they use. And so what RTI found was that state payment rates vary considerably across -- from one another as well as compared to the private pay rates in that state. So there are some numbers in your materials. It's also important to note that those private pay rates do include room and board,
which the Medicaid rates do not.

RTI also looked at what kinds of policies states may use to make room and board more affordable since they cannot use Medicaid funds to pay for room and board in community settings. Some states through the Supplemental Security Income system have provided additional payments to beneficiaries who reside in residential care settings to allow them to afford room and board. Other states limit what residential care settings can charge for room and board, either by setting a cap or by setting a combined rate from which the state is paying for the service portion and beneficiaries continue to pay for their room and board. Some states also allow family members to supplement room and board costs.

The next few slides describe some of the results from the focus groups and stakeholder interviews.

First, in terms of payment rates, stakeholders said that low payment rates compared to the private pay rates discourage participation of residential care settings in Medicaid, and that small residential care settings are most affected because they cannot use private payments to subsidize Medicaid payments. And some of the strategies
that stakeholders said that providers use in response to this is: first, financial screening of applicants and ensuring that an applicant can pay privately for a certain amount of time before they are likely to spend down to Medicaid eligibility; or discharging residents once they have spent down to Medicaid eligibility.

Next, stakeholders were asked a variety of questions about the effects of the home and community-based services settings rule and its implementation. This rule defines the requirements for home and community-based service providers, and these requirements are aimed to encourage beneficiary independence as well as to promote community integration.

As a part of this process, states are currently reviewing home and community-based services settings. They are identifying settings that will be subject to what is called "heightened scrutiny" from the Centers for Medicare & Medicaid Services.

And stakeholders were concerned about small and rural providers mostly and those that are co-located with nursing facilities and how they are going to be able to adapt to the rules requirements, particularly around things
like community integration and giving beneficiaries opportunities to engage in community activities, whether that would be an issue for smaller or rural facilities, and those that are collocated with nursing facilities was another concern.

We also heard from other stakeholders that there's concern around dementia care units which may have elements that are aimed to in some ways restrict or monitor beneficiaries movements to prevent wandering.

Another issue that stakeholders were asked about was the adoption of managed long-term services and supports, which is something that continues to increase among states. And there really wasn't a lot of experience or understanding of what the effects on access would be. Some of the things we heard is that contracting may be a challenge, and based on some of our past site visits to states with managed long-term services and supports, we know that some HCBS providers that don't have a lot of experience contracting with managed care, this is a broad challenge that would also apply to residential care settings.

In addition, care coordination issues may arise
in terms of how are plans going to interact with their care coordination system, with whoever is coordinating the care at the residential care setting. These are unknowns that we didn't get a clear answer from in our case studies.

In terms of other issues, some other things that came up were the fact that the Money Follows the Person demonstration, which does not allow funds to be used to transition beneficiaries with more than four residents, and that was a limitation in terms of where beneficiaries who are trying to get out of a nursing home or other institution where they can go with Money Follows the Person support. Also, current CMS policy does not allow for retroactive payment for residential care settings when eligibility determination is delayed, and some of the states and stakeholders told us that that is, you know, common. And there is some retroactive payment for institutional settings, so there's a discrepancy there.

In terms of future work, we have some ongoing work that is relevant to residential care settings, so I just wanted to make you aware of that. We're currently just beginning to look at doing some analysis of home and community-based services claims data and try to describe
with more granularity what's being spent on different types of HCBS providers. And hopefully we'll have some results to share that will also have some descriptions on what's being spent specifically on residential care settings.

We also have some ongoing work now with Health Management Associates. They are reviewing state contracts with managed care plans and states with MLTSS, and they are looking for network adequacy provisions that are contained in those state contracts. The final managed care rule did instruct states to develop network adequacy provisions, and so we're looking to see what currently exists and where states may need to develop some more network adequacy requirements, and so hopefully we'll identify some that are relevant to residential care settings in that work.

We're also interested in the discussion in hearing if the Commission is interested in additional work in this area. I'll set up in the next slide a few policy questions that might get the discussion started.

So, first, as I noted, the effects of the home and community-based services settings rule may or may not affect availability where it's uncertain right now, but we could do some more analysis in that area. We could also do
some more analysis about how MLTSS adoption may affect residential care settings.

And, finally, the last question is: Should Medicaid policy promote the use of these settings, either by removing barriers that may currently exist or by promoting policies such as those that make room and board more affordable?

So I’m looking forward to hearing your discussion and looking forward to direction on where we might go in this area. Thank you.

CHAIR ROSENBAUM: Comments?

COMMISSIONER BURWELL: So I think this is a great first cut at kind of the issue of the role of residential care settings in the new world of LTSS where an increasing majority of people are being served in non-institutional settings outside of nursing homes.

I see there are lots of opportunities for future work in this area, and I think in order to make a policy contribution in this area, we have to kind of narrow our focus. There are a number of important issues related to the role of housing in community-based LTSS that we may want to tackle, and each of them is a pretty large issue in
itself. I don't think we can -- I would not support, you
know, kind of a broad analytical approach to residential
care facilities. It's just -- you know, there's different
populations, a huge variety of residential models that are
being used, and so I would like our conversation to kind of
hone in on things.

I'll just mention a few, and Kristal has brought
this up. A big one is the settings rule, and where states
are going and CMS is going with the settings rule. I don't
think people really understand what the settings rule is
all about. The settings rule is basically a realization
that the definition of an institution is very -- is not
just related to the physical, you know, structure where
someone is living, but to the kind of life they live
wherever they are. So the settings rule wants to define
community-based services more in terms of the ability of
the individual to live independently. A big one is, you
know, for example, does a person have control over his or
her front door in terms of who comes into their residential
setting and who doesn't? I mean, that's a pretty big deal.
So those kinds of things.

And also the recognition that even though we've
been "successful" in shifting and this supposedly rebalancing thing, there are a lot of people living in community-based settings that are not living the kind of life that we would want to promote from a policy perspective. So there's a lot of work around that. States have -- a lot of their residential care settings are not in compliance with the rules. They have to come into compliance. There's a lot of work that we could do just in terms of monitoring and seeing where that is.

Some of the states have already come in with their compliance reports. I think we should be reviewing those reports as they come in. They will raise a lot of issues, et cetera. That's one.

I think MLTSS is a big component of this. There's no doubt that one of the reasons a lot of states are shifting to MLTSS models is that they think a private sector approach to the development of alternative residential care settings is superior to their own attempt to expand housing opportunities for people living in the community. And I think there's some -- there are definitely best practices out there in terms of what some managed care companies have done in developing residential
Another obviously important piece of this is that MLTSS creates a financial incentive for managed care contractors to find and develop alternative residential care models for their members because it's to their financial advantage to do so. So kind of the intersection of MLTSS and housing development is a big one.

The third is rather than, you know, is there an institutional bias because of this, there is a conversation going on within CMS right now around what are the limits of Medicaid coverage related to housing services. So there's a fairly strict line drawn, Medicaid does not pay for room and board, and that line is pretty strongly drawn. But there's a whole set of services around supporting people in housing. Does Medicaid cover services related to finding housing options for people, housing coordinators, whatever, people whose job it is to expand housing? Can Medicaid cover people to support tenancy in housing, helping negotiate leases, supporting people with disabilities to understand the importance of their relationship with landlords and to not break the lease so that they don't lose their housing? All kinds of housing-related services,
and without getting into the details, that has become a fairly large area of conversation within CMS.

CHAIR ROSENBAUM: With a public document, as I recall. There is, I think, a public policy on this question.

COMMISSIONER BURWELL: There was an informational bulletin put out. The OGC, after it came out, felt like it went too -- had some reservations about it. They've gotten more involved. So there's a fairly large issue, and even though Medicaid doesn't pay room and board, to what extent can Medicaid support people finding and living in alternative settings?

I'll stop there. There's a lot of other issues. I just want to say that in most countries, housing and services are delinked. So the United States is not -- is different in the fact that it often covers an institutional setting -- I mean, a bundled payment for the whole thing. Obviously -- I mean, when you delink housing from services for long-term-care populations, you have to have some kind of financing mechanism or -- you know, for people to find housing. So it's related to what other social programs are out there to support people with their room and board
costs. So that's an issue, kind of how the room and board
component is financed in this new world of community-based
settings is kind of going to be an ongoing issue.

CHAIR ROSENBAUM: So I have just two follow-up
questions for you.

One, among these sort of strains that you've
pulled out for us, is there any suggestion or has there
ever been a suggestion of the federal government using any
of its piloting authority to test out discrete models? I
mean, for example, on number one, you noted that there are
many, many models and approaches to housing. And then this
whole question of managed long-term services and supports
and whether you might test out how that would work were
housing, in fact, to be on a more stable revenue stream.
So I'm just wondering whether there has been any piloting
work, any discussion of piloting work. That's number one.

And, number two, among the three sort of buckets
you created for the discussion, is there one place, given
your expertise in this area, that you'd like to see us
maybe prioritize? How would you prioritize your list?

COMMISSIONER BURWELL: I think I'd like to hear
other [off microphone].
CHAIR ROSENBAUM: Your mic.

COMMISSIONER BURWELL: My intellectual curiosity in this area is quite broad, so I kind of don't want to be forced into picking one at this point. There are a lot of things we can work on, and we can make valuable -- I think we can definitely add to the conversation about housing and services and LTSS.

CHAIR ROSENBAUM: And on the piloting issue, has there ever been an attempt to pilot around this question and to, you know, design a pilot to test it out at all under 1115?

COMMISSIONER BURWELL: Pilot, specific kinds of residential care models --

CHAIR ROSENBAUM: Not nursing facilities.

COMMISSIONER BURWELL: I would say pretty much no. I mean, I think there's a fair amount of -- I mean, the other thing, I'll bring up one other issue, is that obviously when you talk about housing, you're talking about a whole different -- I mean, the availability of housing for low-income people is related to the local market, and markets change. You know, like, for example, in Arizona, there was a huge overdevelopment of assisted living
facilities, and during the last recession, a lot of places that initially were developed as private pay only all of a sudden said, "Oh, yeah, we'll take Medicaid people." You know, so that kind of housing market dynamic fits into the policy discussion.

VICE CHAIR GOLD: Yeah. In some ways, Brian was talking about getting narrower. I have some narrower ideas but in a broader context. I found this was really fascinating. I didn't know much about residential care and Medicaid and I think this work really has helped move things along.

I guess I start out -- I'm not sure that it makes sense to look at residential care in Medicaid without looking at the broad community and home-based services. I mean, I sort of start out by saying, you know, Medicaid -- people in Medicaid, subject to their unique conditions and all the rest, want the same access other people have to services, and my impression is that -- and I think the data support this -- that people, if they can, want to stay at home, and they want to get the support they can. If they can't, they want to go into something like these residential facilities or independent living or whatever
other things exist, and if they have to, then they go to a nursing home or something like that.

And so to work on the residential piece without working on the people -- the supports to people to stay at home, to me runs the risk of just extending the institutional side. So the fact that there is waiting lists in -- and gaps in supply of personal care services, and adult day care, and things that people need, we can't look at residential facilities without also looking at some of those limits.

And we probably also should get to the question of should -- as opposed to residential care -- and this was in the paper, you know, where it's, at least on the nursing facility side, it's a mandated benefit -- states have to use waivers and they can put limits on home- and community-based services. And should that be the right policy? I know part of the concern, I think -- at least it was years ago -- is that if you don't, everyone is going to use these services and you're going to be supporting everyone. Well, it would be very interesting to look at what we know about that. Is it, in fact, true that if you cover these benefits that people will come out of the woodwork and
you'll end up -- the cost would be enormous, or isn't it?

Or if it potentially true, are there offsetting policies that could limit that, that would make it more affordable?

So, to me, some of that is an area for empirical work. So I would tie what we do with residential care to looking at the limitations in support for people at home, and really do some targeting work on what I think -- and correct me if I'm wrong -- but what I think is one of the main barriers to further expanding the community side of things.

CHAIR ROSENBAUM: Yes, Sharon.

COMMISSIONER CARTE: I was wondering about a different aspect of this question, and that would be what leverage would CMS have to describe data in different care settings, going, say, from nursing facilities to residential care settings.

For example, we know that states receive a certain amount of monies for licensure and certification activity, and would CMS be able to leverage some of that perhaps to gather data. And I think we'll hear some similar issues when we take up the serious mental illness roundtable.
But when you look at the question of, for example, cognitive decline for the elderly and how long they're able to remain in a certain setting -- and Brian alluded to this when you look at large assisted living facilities or communities that have nursing homes embedded within them, are we not, you know, in some ways, biased towards helping people who probably wanted to remain more independent and eventually end up in that nursing facility setting? And I think -- I know that this data is not clearly available now but I think we should start to think about templating it out as to what is the length of time that people stay in a particular setting and what affects them changing. What are the transition nodes or the reasons, the factors, that contribute the most to them transitioning, like changes in mobility, falls, death? You know, what are the reasons for discharge and change? What are the lengths of stay? And I realize that there is a real absence of that but a crying need, at the same time, if we're really going to evaluate these different settings and people's ability to remain in one.

Thanks.

CHAIR ROSENBAUM: Kit.
COMMISSIONER GORTON: First, I just -- I want to make sure that we're careful that when we talk about institutional settings we don't restrict it only to nursing facilities. There are ICF/ORCs. There are ICF/ID-DD. And if you look at the, for example, in the substance abuse field, the ACM classification of the different levels of 24-hour facilities, and that leads me to the first observation I want to make, which is, if we come at this through the lens of aging, then the tendency seems to be that you're on a one-way trip to a six-foot-deep hole. But much of the institutional care is delivered to youth. Much of the institutional care is delivered to people who are dealing with ongoing chronic illnesses, who are learning to manage disabilities. If you're newly blind it takes you a long time to get -- to regain your independence, but we shouldn't assume that, you know, you're going to toddle off to the local school for the blind and never emerge.

So I think that there's not enough attention been addressed to the continuum of these things, and really not enough attention to how you move people through, because part of the issue that we have is a coordination and transition and throughout issue. People back up in
emergency rooms because they can't get inpatient beds. They back up in inpatient beds because they can't get 24-hour settings. They back up in the 24-hour settings because they can't move to a, you know, a sober home or whatever else, blah-blah-blah, all the way back down to the community.

So I think it's important as the Commission studies this that we keep in mind the panoply of possibilities with respect to these settings.

So with that as preference, three answers to Kristal's questions. With respect to the rule, my inclination is to say yeah, we probably should study it further. I'm probably not the only person in the room who didn't have the luxury of reading the rule, and I don't feel deeply steeped in it.

EXECUTIVE DIRECTOR SCHWARTZ: We can provide that opportunity.

[Laughter.] COMMISSIONER GORTON: I'm worried about that. But I'm hoping that in its usual exemplary fashion the Commission staff will provide Cliff Notes and point us to a faster path through the various aspects of the rule, as
you've done before. And so I would ask that, in the future, the next time we revisit this, and I hope we will, that maybe we can have a little primer on what's in the rule and what changed.

I know that the whole issue around community life is an important one, and I think it pays -- sometimes what gets defined as community life historically, and I think what I hear is that may still be the case under the rule, is if you get to go to the movies with three paid staff members and nine of your closest friends, then you have participated in an inclusion activity and so you have a real life.

So I do think that that's -- it's an issue in rural communities but I think it's an issue in urban settings, and I think it's an issue in suburban settings. You know, everybody's experienced what has pejoratively been called a mall therapy, where a group of people are taken to a mall and sort of wheeled around for a little while. And that doesn't create value for those individuals, it doesn't create value for the mall, because they don't usually buy anything, and it doesn't create value for the community. So I do -- I think that's
probably worthy of attention. If we're going to include people in communities then they really need to be included in communities.

And so the -- your paper mentions the whole issue of transportation and that's a place where I think that we could afford to do more study. Some states, in certain waivers, pay for some kinds of non-medical transportation. It often doesn't get to a granular enough level that we can take you to the faith community of your choice on the day of the week which that faith community typically gets together. And so if we can't meet something as fundamental as people's faith needs, then it's hard for me to say, yeah, we have them included in their community, and I think transportation is often -- transportation and supervision for people who need supervision is often an issue.

In answer to your second question, yeah, we should study MLTSS more, and going back to the earlier conversation, I do think the plans have a point of view, and to the extent that people are not familiar with the plan's point of view, my experience is that there are precious few people who ever ask us.

And so I do think there's work that could be
done. And, you know, Marsha's point about confidentiality and business, you know, proprietary stuff is there, but we get around that when we need to.

And so I think there should be a consideration of surveying the plans who are currently doing this. Brian talked about best practices. I do think there are some of those out there. Let's find out what the plans think work. Let's ask the plans what they think are the barriers to them doing a good job, and let's ask the plans where, if they're in a state program that has facilitated their work, that we can flag those things. I think that would be useful to do.

The plans will also be able to tell you, in a generic way, how they pay for these things. Is it a, you know, global per diem? Is it some other bundled payment? Are there elements of risk associated with those things? And I think that would be useful for the Commission to articulate.

And then, finally, the word "promote" -- the "promote" word bothers me, because I'm not sure we should be promoting anything. I think we should be offering people choices, and we may not agree with the choices that
people make. What I do think we should focus on is what are we doing that impedes. Right? So you, in the paper, highlighted some policy barriers that impede the move towards home- and community-based service settings.

You know, and I think it would be worth us cataloging some of those impediments. For example, one of the issues is if somebody has a placement in a setting, and then they get sick and they go into the hospital, how do you pay for that placement to be held until they get to go home there? And that's -- it's an enormous challenge because, you know, there's a fundamental tenet that goes through Medicaid that you only pay for one thing on any given day. And so how do you hold a place and not have it evaporate, whether it's an individual's home, or their apartment that they need to pay the rent, or, you know, nursing home, or one of these other places.

So, you know, I think these are all topics that we should get deeper into over the course of the next several years.

EXECUTIVE DIRECTOR SCHWARTZ: Kristal, I wondered if you wanted to just share, because it's not completely obvious in the materials that came, what the role of plans
was in the case studies and also in our previous MLTSS site visit. Could you comment on that a little bit?

MS. VARDAMAN: Sure. Of the states that were included in the case studies, only one, Florida, had managed care, and the experiences of the plans that -- or the providers that we talked to there, the provider community was mainly concerned about the rates and not having experience negotiating with plans before, but there wasn't much on the effects on access.

We didn't hear a lot from -- I think we interviewed one plan in terms of what some of their strategy was, but it's something that we could certainly look more into in the future.

COMMISSIONER GORTON: Yeah, I guess what I would say in terms of sort of ongoing methodological opportunity is I think Toby and I can certainly potentially facilitate a conversation between the Commission staff and the relevant associations, to see if we can't get you an opportunity to get more regular, better, high-grade feedback from the plans. AHIP, historically -- America's Health Insurance Plans, is the big commercial industry, trade association -- traditionally has paid zero attention
to Medicaid. But in the last couple of years, with the changes under the ACA, the expansion and everything else, they've actually begun to staff up and they now have built a whole new staff that are focused on Medicaid, and I think Rhys came over to visit with you.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. On the site visits that we did, it's now been two years ago, correct?

COMMISSIONER GORTON: Correct.

EXECUTIVE DIRECTOR SCHWARTZ: We went to -- I went with you to two places. Did we go to six places or eight places?

MS. VARDAMAN: Five. We went to Florida, Wisconsin, Illinois, Arizona, and --

EXECUTIVE DIRECTOR SCHWARTZ: -- Florida, right?

MS. VARDAMAN: Yes, we went to five places.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah, and in all those places we met with multiple plans.

MS. VARDAMAN: Yes. And in Wisconsin we met with a residential care setting and they were the ones who did bring up concern about the care coordination issue between the plan care coordinators and those that were in the facility.
Also, we are, actually -- I should note that for the MLTSS network adequacy work, we haven't gotten to this phase yet but we are planning to reach out to some plans, once the contractor's looked at the current provisions and contracts, to talk about some of the issues around building a network. And so that's -- since -- you know, hopefully we'll get some results from the contractor view and that will help us determine what kinds of questions we'll ask plans about residential care settings and other providers.

COMMISSIONER GORTON: Okay. Well, that's great. I've noticed, over the six, eight months that I've been doing this, that we seem to have this common theme of, well, we don't know what's going on in the plans, and to the extent that we can orchestrate a mechanism whereby we get some visibility into what's going on in the plans, then I would be happy to support that activity.

COMMISSIONER DOUGLAS: Just a brief question, comment, as it relates on the MLTSS, relates to the intersection with the mega-reg and the in-lieu-of services and how that plays into this as well. Did that come up? I mean, if we -- it's just an area to look at in terms of -- especially of looking at alternative ways to fund
EXECUTIVE DIRECTOR SCHWARTZ: Sara had to step out for a moment to take an urgent phone call. Does anybody else have a question for Kristal? Leanna, you were nodding your head in a couple of places. I wondered if you'd have anything to add.

COMMISSIONER GEORGE: Well, being a parent who has just recently, last month, placed my daughter in ICF, I mean, it is huge area where we need more, I think, attention, especially in the pediatric realms, as Kristal was alluding to. In my state we may have 10 beds or slots open a year, anywhere from 40 to 60 families trying to get their child into that slot. The slot that my daughter is currently in is 4-1/2 hours away from where I live at, so it's like, when I want to visit here I might as well be coming to D.C., because it's about the same drive for me to get here as it is for me to go see her.

So, I mean, and as far as parent impact of, you know, that, obviously, but without this level of support, with the 7- to 10-year wait for home- and community-based services waivers, you know, you look at the news, you hear all these horror stories about, you know, families who are
at wit's end about what to do, they're stressed out.

Something definitely needs to be done, and we're working towards that, but, you know, just from the -- when the rubber meets the road it's a situation that needs to be addressed.

CHAIR ROSENBAUM: Penny.

COMMISSIONER THOMPSON: That just takes me right back to Marsha's initial comment about should we be thinking more broadly about the question of what the benefit structure ought to look like in the program, and also, to Sharon's question about what do we know about where people are, and to Kit's about how they back up in a system, waiting for something to become available that is really the thing that meets their needs.

I mean, we have these lines that we draw, you know, and we talk about the fact that Medicaid isn't paying -- isn't supposed to be paying, I think I would put it -- for room and board inside of HCBS settings, and this question about how we relate the services that are needed to the setting in which they're provided, and the desire for settings to be qualified in a way that really reflects their true nature. But also have, against that, this
question of what people who depend on the program are really looking for and needing.

And I think if we can somehow even just begin to array that and think about that in terms of long-term services and supports in general, I think that could be of great benefit for structuring further inquiry into some of the narrower questions about particular settings and characteristics and payment policy.

CHAIR ROSENBAUM: You know, I would be remiss not to raise a point related to a number of the comments that have come up. This happens to be an area of Medicaid where there has been -- since the Olmstead case was decided, which, of course, dealt with the relationship between the Americans with Disabilities Act and Medicaid, and essentially set certain parameters for how to think through Medicaid long-term allocation decisions into home- and community-based settings.

There has been a very, very extensive set of Olmstead litigation, a huge number of cases, and I raise the issue not so much -- most of the cases actually are decided in the state's favor. But the interesting aspect of these cases, which might be worth looking at, is that
you get a very extensive trial record. You get a lot of
information about the precise nature of the problems and
the barriers, and you get a very clear sense of the
different tools available to states to try and manage
resources in response to needs, and which ones, you know,
seem to fit more with the principles of the ADA, and which
ones do not.

But the cases I have found are extremely helpful
in elucidating just the points that we've all sort of tried
to make, which is what's the nature of the need, what is
the nature of the response, which are the services that are
just, you know, absolutely out of reach for most people
because there's just so little of them, and which are the
ones that they feel, themselves, are the services whose
lack thereof is keeping them in living arrangements that,
of course, are anything but community integrated.

So, again, not to get off on the legal side of
these cases but to get off on the factual and
circumstantial side of the cases, the records are quite
helpful in sort of guiding us through where we spend time.
And, of course, what comes out mostly is the same point
that's now been made several times, which is just these
tremendous waiting lists for certain kinds of services, and those are the waiting lists that are known. So I -- and it's not all room and board. You know, it's so many other services, particularly for children who need integrated educational settings.

Any other comments? Brian.

COMMISSIONER BURWELL: Two additional comments on this issue of community integration. Community integration is one of those things like everybody is behind it, but there's more to it. And one of the issues that kind of has come up in the expansion of home- and community-based services has to do with the tension between safety and risk.

So, by community integration, you mean people are out in the community living normal lives, and people are living in all kinds of residential settings. Inherently, that creates more risk in the system. You have a lot more different types of providers. You have foster care arrangements, people living with individual families. There's a lot of risk in life.

So there have been many instances in states where states have done a good job developing those alternatives,
but then there are fires, and six people die, or there's abuse. It's a more difficult system to monitor in regard to safety. You're in a nursing home, and people express this, "Well, I know my mother is safe there."

So it's a tension that I don't think has been sufficiently acknowledged and is a difficult -- there's no easy answer here.

Second issue of waiting lists, we've done work on waiting lists. There are not good data on waiting lists. You get on a waiting list. I mean, states keep waiting lists, but they're not well managed. People put themselves on six different waiting lists, or once you get on a waiting list, you never get taken -- I mean, they don't follow up. So there's just -- it's a really difficult issue to get your arms around.

I think one fact that we do know is that there are a lot more waiting lists for persons with intellectual disabilities than for the aged. So there's a lot more excessive demand on the non-elderly side than on the elderly side for home- and community-based services.

CHAIR ROSENBAUM: Yes. And, in fact, most litigation does not involve older beneficiaries at all. It
involves younger people.

All right. We do have time for a couple comments.

### PUBLIC COMMENT

* [No response.]

CHAIR ROSENBAUM: Hearing none, we are adjourned until one o'clock.

* [Whereupon, at 11:56 a.m., the meeting was recessed, to reconvene at 1:00 p.m., this same day.]
VICE CHAIR GOLD: Okay. I think we'll get started. Sara had to step out for a couple of minutes, so I'm going to moderate this part of the session.

Katie Weider is going to talk to us about a roundtable that the Commission convened on improving service delivery for Medicaid beneficiaries with serious mental illness, so I'll let Katie describe it. And then both Toby and Andy attended that session, so before we get into general discussion, we'll ask them if they want to add anything to it.

All yours, Katie.

### IMPROVING SERVICE DELIVERY TO MEDICAID BENEFICIARIES WITH SERIOUS MENTAL ILLNESS: THEMES FROM ROUNDTABLE DISCUSSION

* MS. WEIDER: Great. Thanks, Marsha.

So, again, today I will be presenting on themes from a roundtable we had this past June on improving service delivery for Medicaid beneficiaries with serious mental illness. But before I get into the details of the roundtable discussion, I will just first briefly review our
past work relating to behavioral health.

As the Commission will recall, in our June 2015 report to Congress, we had a chapter focusing on the prevalence and expenditures of behavioral health conditions and Medicaid. Following that chapter, in our March 2016 report to Congress, we documented behavioral and physical health integration activities in the Medicaid program. And most recently, this past July, we published a state-by-state review of Medicaid's coverage of mental health and substance abuse disorder services.

Building from our past work, in late 2015 the Commission suggested convening an expert panel on the barriers to delivering behavioral health services in Medicaid. In June 2016, we held that roundtable, which focused on improving issues relating to service delivery for Medicaid adults with serious mental illness.

At that roundtable we had 15 experts. They ranged from state Medicaid directors, CMS, SAMHSA, and ASPE representatives, state behavioral health agencies, managed care organizations, providers, and advocates. We also had three Commissioners attend the meeting: Commissioners Cohen, Douglas, and Rogers.
For the meeting, we focused on a few discussion questions, including identifying gaps in knowledge on Medicaid adults with SMI, barriers to access, and potential Medicaid policy solutions for improving behavioral health service delivery. And from those questions, the expert panel identified six major themes.

One of the major takeaways from the discussion was that more research is needed on Medicaid beneficiaries with SMI. Throughout the roundtable discussion, it was frequently highlighted that there's limited information available on adult Medicaid beneficiaries with SMI. Additionally, there is a lack of standardized definitions and measures, which makes it difficult to compare and assess the effects of interventions when research is available. And here we've highlighted some of the potential research topic areas that were raised during the meeting, which I will discuss later on.

Although the discussion was intended to focus on adult beneficiaries with SMI, many participants underscored the need to address youth with emerging symptoms of SMI and severe emotional disturbance, SED. They also highlighted the importance of early detection, screening, and
prevention programs, and this was a theme that the roundtable continued to circle back on throughout the discussion.

In order to improve early intervention services and also address emerging symptoms of SMI, the panelists suggested improving coordination with the education system and using the free care rule to provide and increase access to behavioral health services.

Our third theme was that there are opportunities in Medicaid to promote more consistent and comprehensive coverage of physical and mental health services for individuals with SMI. The discussion focused on three areas that the Medicaid program could use to expand behavioral health services. First, panelists suggested creating a new optional benefit under a Medicaid state plan, specifically creating a new benefit category for mental health and substance use disorder services. This category could be used instead of relying on the rehab option to provide behavioral health services.

Panelists also highlighted the certified community behavioral health clinics demonstration program. This demonstration is designed to provide a comprehensive
range of mental health and substance use disorder services. Additionally, states can receive enhanced Medicaid federal match for the services delivered by these clinics. Since this initiative is new, it offers an opportunity to examine how this model can improve delivery of behavioral health services for individuals with SMI.

And, finally, with the increasing movement towards Medicaid managed care, participants discussed that managed care organizations have the opportunity to provide specialized networks and services to individuals with SMI. They encourage continuing monitoring of Medicaid managed care organizations serving individuals with SMI.

The fourth theme that came out of the roundtable discussion was that adult beneficiaries with SMI face many challenges accessing appropriate behavioral health services. They noted that this was a multifaceted issue and emphasized a few methods for improving access to care. These included increasing the number and improving the distribution of behavioral health providers participating in the Medicaid program; increasing the availability of Medicaid-covered crisis intervention and community-based services; improving the understanding of federal and state
policies on data sharing; and conducting additional research on provider networks in Medicaid managed care.

Participants also noted that some rules and regulations governing Medicaid payment may create barriers for Medicaid adults with SMI to receive necessary services. They noted that some states prohibit providers from billing for both behavioral health and physical health service visits on the same day. Removing these provisions would likely benefit beneficiaries with SMI.

Additionally, states often limit the type of providers who can bill Medicaid for behavioral health services. As a result, certain providers, such as peer counselors, cannot bill Medicaid. Participants suggested a need for a comprehensive review of licensure requirements for Medicaid providers and changes in policy to reflect current behavioral health practice.

And, finally, they stated that additional research needs to be conducted on who is receiving care in the institutions for mental disease, IMDs; what services IMDs are providing; and the effects of the Medicaid IMD exclusion on access to care for Medicaid adults.

Participants noted the heterogeneity of IMD facilities, and
they noted that IMDs can be classified into five major categories: one, acute psychiatric hospitals; two, substance abuse treatment centers; three, long-term-care institutions; four, nursing homes; and, five, boarding care homes.

Participants suggested that future studies should focus on how the Medicaid IMD exclusion affects the varying populations served in these different facility types. They also noted that this research should be conducted before policy changes are made to the IMD exclusion.

The last major theme that came out of the roundtable discussion was that adult beneficiaries with SMI face multifaceted health and social needs. As a result, they use many other programs in addition to Medicaid, which complicates the delivery of the services they receive.

Throughout the discussion, participants emphasized that better coordination between Medicaid, housing, criminal justice, and education programs were needed. They also stressed a need for a better understanding of how these programs work in concert and in conflict with each other and identification of how these programs fill in each other’s gaps.
Many of the themes that were highlighted in the roundtable supported our past and ongoing work related to behavioral health. On these next two slides, we list some of the questions we're seeking to answer relating to behavioral health.

The first set of questions here focuses on Medicaid's flexibility to improve service delivery. The first question -- How does Medicaid's coverage of behavioral health services differ across states? -- was a knowledge gap that was specifically raised during the meeting, and we're actually very pleased it was raised because at the time of the roundtable, we were almost complete with our state-by-state review of behavioral health coverage in the Medicaid program. So this document is currently on our website, and we believe that we're aligned with the expert panel on this issue.

The second group of questions relates to payment and provider participation. We are currently undergoing work to identify who are the behavioral health providers serving Medicaid beneficiaries and what payment policies affect their participation and provision of care.

Third here is that we have begun our work to look
into how the Medicaid program intersects with other programs, specifically looking at how programs work together, in conflict with each other, and how they deliver overlapping and varying services.

And, finally, we have our analyses relating to access and quality of care. We are building off of our June 2015 chapter and taking a deeper dive into behavioral health utilization and spending, specifically looking at spending and utilization by diagnosis, place of care, and provider type, and how this varies across Medicaid programs and by subpopulation.

We are also looking at dually eligible beneficiaries' utilization and coverage of behavioral health services, and we are also examining spending patterns of behavioral health and physical health services for individuals with behavioral health conditions.

So there were a range of topics covered at the roundtable discussion, and we believe many of the key themes align with our past and ongoing work. So I look forward to your comments and can take any questions.

VICE CHAIR GOLD: Thank you, Katie.

COMMISSIONER DOUGLAS: Thank you, Katie, and
great summation of the report and the presentation, very lively discussion, and meeting that we had with lots of different points of views, and this really did a great job of putting it into the various themes.

What I'd say, I mean, really just in summation of the themes, I think that MACPAC -- that our approach on where we go from research and analysis is the right way that we -- you know, there are so many different interventions that were raised, but really it comes down to we have got to get a better understanding and keep on presenting the data, especially on the access front, and really understanding where spending is going for those with behavioral health to really get a better sense of what interventions are going to work from a Medicaid perspective of physician and behavioral health, and the spending. So I think looking at that, looking at understanding areas of the payment and incentives on providers for behavioral health, so sticking to what we're doing will help address -- it won't address all these themes, but will give us a sense based on that data where some of these themes can actually be effective.

COMMISSIONER COHEN: I have a very similar kind
of reaction to Toby, so, first of all, really great job on the summary. It was a very hard job. The phenomenal array of experts around that table, huge degree of enthusiasm that there is a lot of opportunity to improve behavioral health services for Medicaid beneficiaries, recognition that Medicaid is a huge driver of potentially positive change in this space. But I will say no coalescing around what the sort of key challenges are or the key sort of policy levers. And I think that was -- you know, one of the tough things is that there are so many challenges in this space, but they are not that well documented in a standardized way. Love what's up on the MACPAC website, but it doesn't include what's in waivers, and so much of what's done in Medicaid for the seriously mentally ill is done under waivers. So it's not standardized. The data collection I think is different. And it is just really hard to sort of even identify by data what the real challenges are, although everyone in the room could tell you a thousand challenges with, you know, sort of examples. The issues of state law and licensing, really significant. The issues of workforce, so significant. The issues of just sort of where the clinical research is and
where the -- you know, I would just say like comparative effectiveness and other kind of research is, also challenges, and not necessarily ones where Medicaid policy can lead and make a difference.

So I think one of our big challenges is to sort of tease out what are promising opportunities where Medicaid policy specifically, especially payment policy, can really make a difference.

I agree, looking at issues of, you know, policies around billing on the same day and other things might be a fruitful place to start integrating financing and making sure there aren't unintended sort of erroneous incentives by the fact that we pay one group of providers in separate buckets in many states than we do other groups of providers, and then data, data, data, data, really figuring out what the top priority in terms of how do you figure out what the access issues are and access to what, because everybody, I think, in that room said something about there being issues around access to the right kinds of services, right time, right place, right setting, but there was very little data to back it up.

COMMISSIONER GORTON: So building on what Andy
was saying with respect to the access question, one place
where there's really not a lot of information is people
with co-occurring illness, right? We will often study are
there enough residential settings for people with SMI.
What we don't do is look at, well, but if because of the
atypical antipsychotics this person has been on for ten
years, they also have metabolic syndrome, diabetes, high
blood pressure, right? You call a behavioral health
residential provider and you say, "We've got this person
who's perfect for your program," and they say, "Well, we
don't know anything about diabetes." And so, you know,
okay, that means he can't come, right? You know, children
with eating disorders who also have substance use, you
know, the stuff tends to co-occur. And the interventions
have often been built in silos.

So on my team, we talk about you go to a provider
and you say, "What kind of services do you provide?" They
say, "I'm a red crayon." You say, "What do you do if your
patient needs a blue crayon?" They say, "I'm a red
crayon." So there's work that needs to be done for people
who need the whole eight colors or people who need a box of
64.
And so I would be interested in seeing some analysis on not just access to siloed services aligned with single diagnoses, but on access to coordinated services for multiple diagnoses. I suspect that we'll find that there's precious little out there, but I do think that we ought to try and cast a light on that, because people are not building those integrated complex services. They are building inpatient detox beds for substance use disorder.

The second thing, in Theme 3 I would be interested -- historically, the 1915(c) waivers have been very condition-specific. You could be in an aging waiver; you could be in an HIV waiver; you could be in a DD waiver. But God forbid you were an old person with DD who had post-traumatic stress from living in an institution for 40 years. There was no way to get you all of the right sets of services because the service you need for your PTSD is over there in the SMI waiver, right?

So I would be interested -- and I don't know that I've ever seen this -- in looking at where states have used 1115 authority to maybe mesh stuff together -- I don't know if they have -- or if states have been able to be creative with 1915(c) authority or others to try to pull things
I know living in managed care in 1915(b) land, we run into these barriers all over the place, and so I think it might be useful, if there are best practices out there on how to try and make these things line up, to elucidate that; and if there are not, then to identify the barriers for why nobody has come up with the best practices, because these are obviously pressing problems.

And then the third piece -- and maybe this came up and you just didn't have space in what was a summary of what seems like a very meaty meeting. But I was surprised that race, language, ethnicity didn't come up, cultural competency didn't come up in Theme 6, because it is incredibly difficult, particularly for people with limited English proficiency, to even begin to be addressed by the behavioral health system, right? So, you know, you have people who have come across from China in containers. They only speak Mandarin or Cantonese. They come from a culture where the stigma associated with mental illness is profound, and the last thing they want to do is tell somebody they're thinking about killing themselves. And then they need specialized treatment for PTSD.
And so, you know, or we have a set of Ugandan refugees in central Massachusetts. They speak Swahili. Many of the women have been gang raped in conflict zones. So these are people who are confronting some pretty incredible stuff, and if we can't come up with a culturally competent way to address their needs, then what happens is they live their silent horrors off by themselves.

And so I would be interested in, again, can the Commission either elucidate best practices in dealing with limited English proficiency and other cultural competency issues on the behavioral health side, or if there are best practices, to point those out to other people.

VICE CHAIR GOLD: Yeah. Sharon.

COMMISSIONER CARTE: In looking at the question about what we know and don't know about Medicaid enrollees with SMI, it seems like a really essential question. I think it was a GAO report of about a year or two ago that talks about this relatively small percentage of SMI enrollees in Medicaid, around 5 percent, but utilizing 20 percent of expenditures in Medicaid. And that kind of spread just tells you that we really need to have more data. It seems like it would be in the interest of all the
states and CMS to be able to have a measure that indicates
the denominator of all people by state and a numerator for
those people who are getting -- SMI folks who are getting
services. And that would include the home- and community-
based folks that Andy talked about, and that we would
further be able to look at the data for the intensity of
services received by those folks as well as the setting
which they receive it would be important parameters.

VICE CHAIR GOLD: Katie, people have had a number
of comments. Was there anything that you wanted to ask or
react to?

MS. WEIDER: No, not at this time.

VICE CHAIR GOLD: One suggestion I had was, as
you look at this utilization data, think about the "so
what?" question that will come afterwards, and I don't know
if there are any metrics that have guidelines or
suggestions as to what's better or worse access or better
or worse care that you could build in or maybe just look at
some surveys that if they're specific to this group that
you could combine them with, because the numbers are
useful, but often they raise as many questions as they
don't. And if we can anticipate sort of the normative
COMMISSIONER CARTE: I should add that the impetus behind those questions, Katie, comes from looking at Washington State, where they're starting to look at these issues, and because we've turned over so much of the care to managed care, that they're looking at using these kinds of measures, both towards determining case mix and acuity, and also penetration, how many services when you have that numerator and denominator it's showing you. And you can look either by your regional services or by MCO, what kind of penetration you're seeing for this population. VICE CHAIR GOLD: Any other comments on this topic? [No response.] VICE CHAIR GOLD: All yours, Sara. CHAIR ROSENBAUM: All right. So we are now turning to Tab 6 for a discussion about Medicaid financing and provider payment policies with Moira and Chris. [Pause.] *** THE RELATIONSHIP BETWEEN MEDICAID FINANCING AND PROVIDER PAYMENT POLICIES * MS. FORBES: Thanks. So thank you. I felt like
so -- additional three feet, really very far away.

So the Commission has been discussing Medicaid financing partly in response to concerns raised by policy-makers about the level and rate of growth of Medicaid spending. Medicaid is, of course, financed by both states and the federal government.

Earlier this year, we focused a lot on alternatives to the federal financing approach. Today, we're going to talk more about the non-federal financing side of things -- or state share and in particular how this relates to Medicaid payment policies, and we'll note some of the implications that this raises for future Medicaid policy.

Medicaid financing is structured so that federal funding is available to match state contributions. As you recall, last June, the Commission published a report chapter on federal financing and options for systems that limit federal contributions, including block grants, capped allotments, per capita caps, and shared savings arrangements.

Medicaid has always been financed through both federal and non-federal contributions. The non-federal
portion can be generated through a variety of mechanisms. This reflects the various systems for providing health care for low-income populations that were in existence at the time that Medicaid first came into existence and were used by states at the time.

Some of these are listed on the slide here. They include general revenue, CPEs and IGTs, and provider taxes. There are limitations on some of these mechanisms. For example, 40 percent of non-federal funding must come from the state and not from local or provider contributions. Congress has imposed some restrictions on some of these sources over time. For example, health care-related taxes must be broad-based and uniform. They cannot hold providers harmless. Sources of non-federal financing are subject to federal oversight, although CMS has noted that the data it collects on sources of non-federal share are unreliable. And states vary a lot in their uses of the different mechanisms, as we'll talk about a little more on the next few slides.

These data come from a 2014 survey that GAO conducted, which is the best source of information currently available. As you can see, the majority of the
non-federal share of Medicaid spending is from state funds, mostly state general funds. About a quarter of Medicaid spending is from local and provider contributions, and a small amount is from other sources.

The previous slide showed that states overall financed about a quarter of the non-federal share with contributions from providers and local governments. This map shows, like so many of the things that we talk about, the extent to which the non-federal share comes from local and provider contributions varies a lot by state, from zero percent to just over 50 percent, according to the data collected by the GAO.

The GAO survey asked states about sources of state share over time and found that state use of contributions from providers and local governments as a source of non-federal share has increased over time, while the use of state funds has decreased.

The GAO also found that the percentage of the non-federal share of supplemental payments financed with local and provider contributions has been relatively high and is increasing.

From this set of facts, there are two different
interpretations that are at odds with each other. One view, which states generally hold, is that states are making effective use of all legally permissible funding sources to generate revenue to support the Medicaid program. The other perspective is that states are using funds from providers and local governments to inflate federal contributions in the overall Medicaid budget without additional state contributions. As you can see, that second perspective is played out in some federal policy responses described in the next slide.

In response to the concern about the effect of the increased use of local and provider contributions on overall Medicaid spending, various ideas have been proposed that would disallow or limit specific sources of non-federal share. For example, local contributions such as intergovernmental transfers or certified public expenditures could be disallowed, or the Medicaid provider text threshold could be reduced below the existing law level of 6 percent.

It's not clear what effects these policies would have on states that rely on these sources in part because, as noted earlier, there's not much information on the
extent to which states currently rely on these sources of revenue to generate their non-federal share of Medicaid spending, and we don't know what alternatives states would use if any of these sources were disallowed.

However, we used available data, as Chris will discuss on the next few slides, to estimate how the increased use of these financing mechanisms affects the split of federal and state funds nationally.

* MR. PARK: Thanks.

To estimate how state financing options affect the split of federal and state funds, we used the GAO survey data on the extent to which each state uses various sources of non-federal financing.

We tried to estimate how much of the non-federal share was contributed by providers and local governments and then returned to those providers through provider payments, because these provider contributions do not necessarily contribute to the net payment that the provider ultimately receives, and any increases in the provider payment associated with this source of financing are largely funded through federal dollars.

We do not simply want to remove all of the
dollars associated with these provider contributions from providers and local governments. In certain cases, these dollars do not necessarily go back to the providers. For example, the amount contributed through provider tax, this generally goes back to providers. However, an example is Colorado where they do have a hospital provider tax, but they use some of their provider tax revenue to fund an eligibility expansion. So we made some assumptions about how much of the different sources of non-federal share were returned to providers and apply these assumptions to the CMS-64, financial management report data, to estimate the amount of federal spending associated with this portion of the non-federal share.

From this analysis, we found that there was a modest increase in overall federal share, once you adjust for provider contributions. The average federal matching rate, that is, the ratio of total federal spending to total Medicaid spending, is about 57 percent in 2012. We've removed the non-federal share contributed by and returned to providers from total spending and recalculated this ratio. Once we have recalculated this, the federal portion was about 61.7 percent, or about 4.7 percentage points
above the average federal matching rate that we saw before.

Of course, there was substantial variation across states. So this graph shows the distribution of states by the percentage point increase in the federal portion of total spending once we made the exclusion for provider contributions.

As you can see, the majority of the states, 31 states, have between a zero to 4 percent increase in the federal share. You can also see that any policy changes that affects how states can raise the non-federal share would have a greatly different effect, depending on which state you're talking about.

MS. FORBES: So just to pull together some of the facts from this presentation and also that were discussed earlier today, contributions from providers and local governments are an important component of Medicaid financing. On Slide 6, we showed that states financed about a quarter of non-federal share from health care providers and local governments, and as the GAO found, funds from providers and local governments have increased as a percentage of the non-federal share, while state funds have decreased.
Supplemental payments account for a large proportion of total hospital payments and are increasingly financed through provider contributions. MACStats data from 2014 showed that supplemental payments account for about 44 percent of total hospital payments, and again, the GAO found that the percentage of the non-federal share of supplemental payments financed with funds from providers and local governments has increased.

As we showed in the hospital index analysis this morning, Medicaid hospital payments, net of both supplemental payments and provider contributions, are not excessive relative to cost or compared to Medicare payments.

And, finally, when we look at all of this together, the relationship between the state approach to financing non-federal share and provider payment policies, including supplemental payment policies, is complex and raises two sets of linked policy issues.

Some of the policy implications to consider include:

The changes to the federal financing structure will have to address whether existing differences in
The states currently exercise flexibility to generate revenue to support their programs that results in, as we saw in the map, a lot of differences among states in how they finance their programs.

That financing mechanisms raise questions about accountability and transparency, particularly when there's little data available at the provider level, as we've mentioned several times today.

On the payment side, we continue to find that the use of supplemental payments complicates efforts to tie payments to value, and while we didn't get into managed care here, the rule that came out this summer largely maintains the explicit prohibition on making supplemental payments to providers outside of capitation, which requires states and CMS to go through the waiver process to keep that money in the system, which adds complexity.

So we hope this information is helpful as the Commission continues its discussions on Medicaid financing and payment policy. We realize this is just the start of a conversation, and there may be more open-ended issues or
there may be specific things for us to follow up on. We thought that, first, Chris can answer any technical questions you might have on the analysis, and then we're happy to answer whatever else we can.

CHAIR ROSENBAUM: Penny, will you lead us off, and then we'll take it from there.

COMMISSIONER THOMPSON: Sure. So we'll start with the technical side. First of all, thank you very much. I've been dying for this conversation.

Just to review the trend lines, you referenced 2008 to 2012 when local government and provider funds increased and increased as a share of the supplemental payments. Do we attribute that to states under fiscal pressure from the economic downturn, looking for other resources of revenue?

MR. PARK: So that data came from the results of the GAO survey, and I think that is one of the factors they mentioned that would contribute to that trend, is that during that fiscal downturn, they started using these different sources of contributions more.

COMMISSIONER THOMPSON: Okay. When we talk about the two different views on what this means, it seems to me
that, actually, those can both be true. It can be true
that states are using all legally permissible means at
their disposal, just as we as taxpayers try to take
advantage of everything the Tax Code has to offer us and,
in so doing, maximize finances to our advantage.

I want to ask a little bit about this calculation
that you're doing and the judgments that you made about
what was and was not returned to the provider. This is a
little bit of what we started talking about earlier today.
I mean, to some extent, it almost feels to me like a
formula that answers itself, which is if you take out a
source of funds and you take out payments and you only
leave in the federal share, it will naturally inflate the
federal match. You are talking about the elements that are
actually on one side of the equation, and you're leaving in
the element that's on the other side of the equation. So,
by necessity, it will have that result. So I think we need
to scrutinize and examine how we made the decision about
what we're taking out.

So I understand taking out provider contributions
because that's what we're testing.

MR. PARK: Sure.
COMMISSIONER THOMPSON: But you're also taking out expenditures made under federal and state rules about what constitutes a permissible expenditure to the providers that were also the source of the funds, but those expenditures may have produced value to the Medicaid program. They may have represented a payment. In fact, by necessity, they did. They represented something that the Medicaid program thought it was getting as a result of that expenditure for which the federal match was allowable.

So can you talk a little bit about what you put on what side of the ledger for an expenditure that you left in and an expenditure that you took out?

MR. PARK: Sure. We made some very high-level assumptions because we don't have very detailed information about exactly how every state uses provider taxes or CPEs or IGTs. So we can't make very detailed assumptions at the state level.

What we wanted to try to do is -- we've looked at a few states to try to get a sense of how they're using the different sources of funds and make assumptions about whether those particular sources, such as provider taxes, have a strong link to the provider making that
contribution, and then in an aggregate sense across all providers of that class, they are getting most of that money back alongside the federal share.

We try to make this calculation based on this viewpoint that -- the second kind of viewpoint where states are able to make increased payments to these providers because they are able to draw down that additional federal share. So, when you look at what the provider contributed and then got back, they really only netted basically the federal share at the end of the day, and so this gets to that second viewpoint of that.

The states are able to increase provider payments for very valid purposes in most circumstances, to increase access or provide incentive payments to hospitals, better quality, but if you look at it from that one viewpoint, then the federal dollars are a greater percentage of the payments to those providers than what you would typically expect for the normal FMAP rate. That was what we are trying to do with this calculation. We are making very gross assumptions. So, to that point, there are very valid assumptions plus or minus from where we've made them as to whether the contributions from providers or from local
governments are kind of being used in that purpose versus being used in a more general sense to support the entire Medicaid program and doesn't have as direct of a link back to the provider.

EXECUTIVE DIRECTOR SCHWARTZ: Chris, it's correct that we have a different assumption for each source of revenue?

MR. PARK: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Because we are trying to set up the broader discussion here, we didn't give you all that documentation, but we can. We can also do sensitivity analysis about those assumptions, and so before we go further with this, we can certainly share some of that with you. And there's documentation for each assumption and why it's higher or lower for a particular source.

VICE CHAIR GOLD: Can I ask a clarifying question?

MR. PARK: Sure.

VICE CHAIR GOLD: Because I'm sort of confused with the two parts of the analysis. In one you're talking about provider payments and intergovernmental transfers,
and then here it seems like you're talking about provider payments. And I actually agree that it's important to make the distinction among them, but I want to make sure I understand what you -- which part of the ball you're taking out. And I think we have to be careful around the language not to mess -- get it all mixed up, because each of these things can be looked at in different ways from a policy perspective.

MR. PARK: Sure, and, you know, this is where the assumptions came into play. So we didn't want to simply remove all the non-federal share that were associated with provider taxes or contributions from local governments, because, you know, not all of these sources are directly tied to a payment policy. You know, they could be used to support, like administrative services that the state provides, or as in the case of Colorado, they used some of that money to support eligibility expansion.

So at a certain point -- and this is a very fine distinction and one that, you know, people will definitely argue about, and, you know, why we are making some very gross assumptions at this point but we can provide sensitivity analysis around it.
EXECUTIVE DIRECTOR SCHWARTZ: And also, we're still doing this at the aggregate level, so to Penny's point, about, you know, there have to be winners and losers, what we're still seeing is at the aggregate level there's a gain, even if at the institutional level it's not a quid pro quo.

COMMISSIONER THOMPSON: So it is fair, then, to describe this as almost our analysis is kind of the worst case scenario for what the implication is to the federal side, that if you believe that the funds that the providers are giving the state to use as its state share are drawing down federal dollars for expenditures that have little to no value other than to make the provider pull, who provided the initial contribution, that this is the effect?

MR. PARK: I wouldn't say it's the worst case, because we didn't -- for example, we could have assumed that all provider tax dollars were being returned back to the provider.

COMMISSIONER THOMPSON: Well, that's kind of an extreme case.

MR. PARK: Right.

COMMISSIONER THOMPSON: I mean, like a rational
worst case --

MR. PARK: Yes.

COMMISSIONER THOMPSON: -- like our idea of a worst case would be this --

MR. PARK: Yes.

COMMISSIONER THOMPSON: -- because it presumes those dollars that came back to the provider really brought nothing of value to the Medicaid program.

EXECUTIVE DIRECTOR SCHWARTZ: But that's not what we're saying, Penny. I mean, you added in adding no value to the Medicaid program and we didn't make a judgment about that. You're saying it's a question of whether --

COMMISSIONER THOMPSON: That's what's implicit in taking it out of the equation, in my view, because what we're saying is there was a federal share that was generated as a result of the provider contribution. The expenditure that that federal match was matching, that those federal dollars were matching, was -- we're using the word "returned to the provider." If it had gone to, say, a provider that didn't provide that contribution, we would have said it belonged still in the equation because it bought something.
So that's my point, which is implicit in the analysis is the idea that the return to the provider is effectively in recognition of the contribution, as opposed to what a supplemental payment or other kind of payment would need to qualify for, which is for a certain service or activity, of value to the Medicaid program.

MR. PARK: Yeah, so I think the way -- you know, this kind of links back to the hospital payment index --

COMMISSIONER THOMPSON: Right.

MR. PARK: -- in terms of how does this actually contribute to the net payment that provider has received. And so if some of the tax dollars went to a different provider class --

COMMISSIONER THOMPSON: Mm-hmm.

MR. PARK: -- that did contribute to the net payment. So that particular source of non-federal share did contribute to the net payment of another provider.

If it went from, you know, one provider class and was returned back to that provider class, in general, then it didn't necessarily contribute to the net payment and the federal portion of the dollars that went -- you know, in terms of the net payment, were higher. And so that is kind
of the calculation that we made.

And so, to Anne's point, you know, we weren't necessarily trying to make a value judgment that, you know, these were not justified or there is no value associated with it. It's that, you know, federal dollars at the net level were a little bit more because of the way that it was financed.

COMMISSIONER THOMPSON: Why don't I stop there and see if others want to jump in on those technical points.

CHAIR ROSENBAUM: So I have Alan and I have Andy, I have Marsha, Toby.

COMMISSIONER WEIL: I don't know if this qualifies as jumping on a technical point. I think I share some of Penny's concerns, although I wouldn't frame it quite the same way about no value.

I get hung up on the language also but maybe in a slightly different way, and I realize that we all sort of revert to shorthand. But I think terms like "state match" are not helpful, because this is not a state-matching program. This is a state-run program for which states can receive federal financial participation for allowable
And so that's why I don't have the problem, Penny, you did, is that what I hear being said is the state match is lower than we think it is, and I guess my response to that is there is no such thing as the state match. So that's not the implication I want to -- what I want to work from.

And I -- so where I go back is to, as you did, bring us back to sort of the rate discussion this morning, to sort of think, given these two narratives -- and I completely agree, Penny, they can both be true -- there are a couple of different ways to go with the implications of this analysis, and I think one of them, which is an area where there has been a lot of policy-making, is around the federal policy response to the notion that if providers are contributing money they shouldn't get it back, and you have limitations on all of that. That requires a very focused analysis of the financial flows. That's not an aggregate analysis. That's a very targeted analysis, situation by situation.

The other policy direction to go with these kinds of analysis is the overall assessment of the financial
structure of the program. Should it -- should we change
the structure? Should we change the match, the federal
participation? Should we -- you know, what are the
implications of block-granting in terms of how it locks in
various things? This kind of analysis, I think, is helpful
for that. What I worry is it gets used for the former,
where you need a finer lens.

So what I'm trying to do, similar to this
morning, is think about the technical issues that need to
be addressed to use this the way I think you intended, but
to not pretend that this will ever be the right mechanism
for figuring out the policy response to concerns about
recirculating money, because that's just -- that's a whole
different place to go.

And so that brings me, again, sort of back to
where we were this morning, which is that, you know, I'm
not going to add a lot to the technical questions that
Penny asked, but I think -- I know you didn't say it's the
worst case and I agree it's not, but it does feel, to me,
like this does reflect sort of an upper bound of what you
would think of as the possibility that federal dollars are
flowing without the state putting in its share. My
problem, again, with that is that that's not how the
program is designed so I'm not sure I even want to use that
language.

That's my reaction to that.

CHAIR ROSENBAUM: Okay. Andy then Toby then
[inaudible].

COMMISSIONER COHEN: Um, fascinating. Again,
long-term conversation. I was surprised that the upper --
let's call it for the moment the sort of reasonable upper-
bound number was 4.7. I think that's lower than most
people who have been engaged and work in this program would
have thought over the years, so I think that's an
incredibly interesting finding. I share all the same
concerns about use of the analysis, because of the nature
of having to lump so many things together.

And I just, for purposes of illustration, just
want to offer the example of New York, which requires its
counties to make really substantial contributions towards
state share. It comes from tax revenues, general revenues.
It goes to the general pot of the state for, you know,
getting matching and paying providers, and it's really
substantial. I think New York City spends well over $5
billion a year of city tax levy dollars on these things.

So, I mean, that is not recirculated money. That is simply money that has come from a different tax base -- actually the same tax base; different taxing authority.

So, anyway, I just think that, you know, and it's a huge program, and California has, I think, some similar kinds of things that -- you know, and those are two of the biggest programs in the country. So those, you know, those facts are extremely relevant to this notion of the upper bound of what we're really trying to get at, which is the possibility of sort of recirculated money, and the I-know-it-when-I-see-it kind of test.

CHAIR ROSENBAUM: Okay. Toby.

COMMISSIONER DOUGLAS: Just first, just to understand. Technically, were those -- like what Andy described -- are those included, because they are big, big dollars.

MR. PARK: So, again, like I said, we did not try to do everything at the state level. So we tried to do kind of like a high-level assumption that we applied to every state. So, in that case, we -- for example, for like New York or California, we may have overestimated the
amount of money that we took out, because, you know, those
are examples where it's not necessarily coming from a
particular provider class.

COMMISSIONER DOUGLAS: Yeah. I mean, I think one
ingredient -- and this gets to the buckets of CPE versus IGT and
provider taxes -- the CPE -- you know, there was a way -- I
mean, that is, as Penny said, a cost. And so there's a way
to, you know, look at that separately.

MR. PARK: Yeah. So we --

COMMISSIONER DOUGLAS: No, no. Go ahead.

MR. PARK: Oh. So I was going to say we did
assume that a lower -- we did remove a lower percentage
from CPEs than we did for provider taxes or IG Ts.

COMMISSIONER DOUGLAS: Okay. Okay.

And then, I mean, I don't want to say a lot.

One, the same, this is such an important area. I do get
very concerned of how it's going to be used, and, you know,
and not critiquing -- just the word "value" really scares
me, because a delivery system, regardless of how the
payment, it's still essential to the system that they have
today. And so any discussions about this, when you're
talking now in the context of changing the financing, has
to start with, this is the states -- both of those statements are true. They've been using permissible ways to fund the program and yet it is true that it can be viewed as distorting the federal-state ratio.

And so we now need to look at financing from that starting point if we're going to make any changes, that this is important funds within the system that are stabilizing the delivery system and any changes can't just suddenly take those away.

CHAIR ROSENBAUM: We have Stacey and then Marsha.

COMMISSIONER LAMPKIN: So this has been so educational for me to hear how other people think about this, so I really appreciate that.

With respect to the netting question, I think it's very understandable from a more layperson like me, with less regulatory background, to understand how this feels like a relevant question. And so we really do have -- it seems like we can't ignore it but we just have to be very careful about how we talk about it, and perhaps put some illustrative examples around to help people with their thinking.

And I think of a couple of hypothetical examples
that have nothing to do with supplemental -- fee-for-service supplemental payments but in a budget constraint situation. So you might have an example of a hospital tax being implemented or being raised to help mitigate the effects of a budget cut, but it's a broad-based hospital tax. And so that's one example of a technique that maybe feels like less important to net out of a calculation as contrasted with another one where we've got a budget situation, and now if there are hospitals who have access to IGTs and want to buy back their cut, they can do that.

But other hospitals without access to something cannot, and then you introduce a different kind of dynamic there where if the service would be provided anyway, absent the extra money coming in, it feels like there is a federal share consequence that may be, not technically, a state match question, or it's still an expenditure, but there's something there, whatever you call it.

So I don't know how we talk about this in the more nuanced way. Because of these kinds of nuances I would be leery of the calculations just in understanding kind of the broad-swath assumptions that had to be made.

It seems like, though, with those examples, that
these are areas that CMS has the ability to monitor through reimbursement methodology and its effects on access. So if they see a situation where the reimbursement methodology is producing access issues or disparities from one hospital to another that don't make sense, that there's already a mechanism to monitor and kind of keep a lid on that. Is that fair?

COMMISSIONER THOMPSON: Well, I'll just jump in to answer that question. I think there are guardrails but they aren't necessarily individual judgments. So you have a -- you know, you have a guardrail around the UPL, which we've discussed here, which is, are the total expenditures to that class of providers reasonable, without necessarily saying every individual rate paid for every individual service to every individual provider in that class are what we would judge as reasonable. There's requirements for developing and publishing rate methodologies, but again, that doesn't always talk about what the actual expenditure arising out of that methodology will be. And then there's requirements to provide access.

So there's sort of a whole bunch of things that kind of circle around it, without trying to get the federal
government into the business of approving individual rates.

CHAIR ROSENBAUM: Marsha.

VICE CHAIR GOLD: Yeah. Some of -- if some of my question is because I don't understand the accounting terms there, please correct me, because I don't -- I mean, I'm not an expert on all those accounting terms that you're lumping together here.

Here's what I'm concerned about. Just like in the federal government you have the states, as to what the role of federal government and the state should be. In fact, it's not what the federal government or the states -- it's that the states also have very complex relationships with their localities and cities, and they could even differ within the same state for the big cities versus the counties. Some of those are laid out in constitutions, they're part of state law. All those things affect who's responsible for health care, and who's responsible for financing health care, and I think it's why, in states like New York, the counties pay half -- or certain counties pay half of the state match, or whatever the right answer is to that, and in some other places it's there.

And to my mind, I don't know why we're even
looking at that. That's a function of state and federal
relations that's defined by law. What I thought we were
looking at is sort of payments that we think may have maybe
sort of going in many directions at once in different ways.

And so I'm still concerned that while we're
trying to look at provider payments, we're lumping it
together with stuff that I think is just statute and part
of practice, if, in fact, we're doing that, and I would
prefer that we separate that out or leave it out, whichever
you care, but not mix it together, because it's -- we could
have a debate. I personally think there's more of an issue
of provider payments that go back to providers than
worrying about how the states and localities divide their
financial responsibilities for paying for Medicaid.

CHAIR ROSENBAUM: Let me just follow up on that,
and your point was very well taken, and Alan's earlier
point.

What we have going on here -- let's park this
morning's discussion on how providers get paid. This part
of the discussion is really a fundamental -- the
fundamental tension between tax law and public welfare law.
Okay. From a public welfare law perspective, Medicaid
says, as Alan pointed out, and literally this is how the program works, that if a state spends money, the federal government contributes according to a formula for approved expenditures. The operative word is "spend." Okay, what does it mean to spend?

And federal Medicaid law has taken, historically, because it was built on all of the medical indigent programs that came before it, took a very generous view of what it means to spend. You could spend by spending cash. You could spend by foregoing revenue that you might otherwise collect, that your locality spent on indigent care programs. You could spend by supporting public hospitals in the state.

Over the years, we've gotten a little more refined in the word "spend," and so we have certain ground rules for, you know, when we count something as an expenditure and when we don't, for federal contribution purposes. But if you put on sort of your tax law hat, and this issue of the constitutional relationship between state and federal governments, it is a tremendously substantial leap to have the federal government say to a state, beyond certain modest things like, you know, we want to see that
you actually have a tax coming in, that there's really
money in a tax scheme coming in, for the federal government
to say if you don't follow our kind of taxation
arrangements for your Medicaid program we won't match it.

If you said no more local spending on Medicaid
you're essentially saying to state, you must impose a
state-level tax and not just have revenues foregone that
are the result of a local taxing base. You know, if we
don't allow any more taxes on, essentially, the sale of
hospital services to the state, or to private insurers in
the state, you know, if you use that kind of a tax we won't
recognize Medicaid spending anymore.

I mean, in other words, there comes a point at
which not just politically but also as a legal and
constitutional matter we find ourselves in uncharted waters
and I think we find ourselves on issues -- in the middle of
issues that are so extraordinary issues, quite frankly,
compared to anything that's come before, compared to a UPL
payment rule, or a provider tax rule, that I think -- I
feel, personally, that our better focus is on what do
states do. How do states invest the money that they
generate through their spending arrangements that are
approved under law, and are there more effective and
efficient ways that we might think of in making
recommendations to Congress? But in terms of fundamentally
altering the federal-state relationship over tax policy is,
to me -- you know, we are venturing into an area that we
are not really equipped to deliberate.

I mean, for starters, I would want to know how
all social welfare spending happens in states. I would
assume that states diversify their revenues for all kinds
of programs--education spending, social service spending,
correctional institution spending, highway spending. I
mean, you name it. States come up with all kinds of ways
to generate the revenues they need, and that is an area of
great, you know, policy import to a state. I think that
Medicaid can lay some ground rules about when, you know, we
count state expenditures and when we don't, but I'm not
sure that we want to be recommending these issues that I
think sort of fall into tax policy as much as they do
health policy.

And I think it's reinforced, sitting here and
listening to this, it's reinforced, for me, by the fact
that we're working at a high level, so we can't really
follow the trail of funds. We don't see any evidence that
there's a -- you know, a direct correlation between the
taxes you pay and the rates that are set and the money you
get back. And, in fact, federal law prohibits that.

So what I do think we need to be concerned about
are, you know, are rates being set for programs in ways
that generate efficiency and quality of care, or other
things that we might worry about. But this is a huge
issue.

COMMISSIONER THOMPSON: Yeah, just to follow on
that point. So I just wanted to come back around then to
some of the questions about what are we doing with this and
where are we going with it. I've been, you know,
consistent in saying I'm more interested about the
expenditure side of the equation for some of the same
reasons that Sara and Marsha have talked about, which is,
you know, a little bit of -- the concern around the
provider contributions and kind of where I was going
initially with our calculation and representation is a
little bit of the idea that a provider is making a
contribution, the state is using that to generate an
expenditure for which there is a match, that ultimately
ends up in the hands of the provider that initiated the transaction to begin with, and in the end that the provider is out nothing, the state is out nothing, and it is the federal government that is paying whatever is being paid, which means -- and this is where, Anne, I was going originally with by definition -- that nothing happened that was really worth that initial state expenditure, which means it didn't really produce value to the program. So I'm more interested in ultimately those issues present themselves because it's an unusual circumstance. I mean, it's not unusual for a state to, for example, raise revenue from a regulated industry, to regulate that industry. What is a little different here is that you have a group of providers, let's say, who are actually delivering services and who are actually the engine by which the program operates, and they are contributing funds that ultimately get put together with federal dollars to pay them for the services that they provide. And the skepticism from some people comes in the entanglement between those two sides. I think it's more easily analyzed, though, by looking at the expenditure side of the equation, which is
where are the expenditures being made and on what basis and for what services and outcomes and values for the Medicaid program. And, again, we come back to the age-old supplemental payment issue of trying to understand supplemental payments, where they're going, what they're buying, and what they're generating in terms of goods and services for the Medicaid program.

There's been various proposals that people have made over the years about -- you know, GAO has been active in this area for a number of years making -- and the Inspector General's office at HHS -- making arguments that I haven't been supportive of, for example, about limiting public hospitals to cost, mostly just because I think that we should be promoting value, and sort of going backwards to kind of cost-based systems doesn't seem like the right direction to me. People have talked about kind of provider-level UPLs, which I don't know if they're really workable or not workable, heightened scrutiny or transparency around the supplemental payments and where they're going and what they're doing and better reporting and all of those kinds of things, and maybe some changes around what states have to do in terms of combining all
sources of payments to providers or generating certain kinds of financial reports that would help provide some insight into this. I think that kind of culling through those questions and thinking about whether those particular kinds of recommendations are ones that we would want to support, as well as others that we could come up with, I think putting some effort into that payment and expenditure side for how do you -- which is -- this is a very difficult question. How do you decide that a set of payments made to a provider are efficient and effective? We saw earlier the variation among the states, and payment methodologies and total dollars and how we calculate that. So this is not for the faint of heart. But I do think that it is kind of ultimately the question, that if you have something that you're paying that's producing value and goods and services that you want to recognize, then the source of the funds that contributed to the state expenditure are less relevant.

EXECUTIVE DIRECTOR SCHWARTZ: I'm going to push back a little bit because I think we need -- the staff need help in figuring out what the next step is, because I'm
trying to think, Penny, about if we want to get where 

you're talking about, what would be some of the 

intermediate things that we could do that would help 

eliminate those questions for you. And I'm having a hard 

time trying to think about what's the analysis that we 

could do of -- given the data we have, having already noted 

the many limitations, particularly on the provider level, 

what kind of analysis do you think would be compelling to 

help us figure that out? Because we can -- I mean, we can 

look at expenditures across states, you know, per person. 

We can look at certain types of services. I don't think we 

have a good benchmark to judge, you know, sort of the 

correlation between supplemental payment and, like, were 

those services good services or not good services, or, you 

know, is the level of payment too high because we can't 

really get at that?

So I'm just trying to -- I'm kind of grasping at 

straws here about like what --

CHAIR ROSENBAUM: Where should you go.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah, what could we 

do specifically -- like what data would you find compelling 

to help us move to the next step? Because that's what we
really need help on so we can have the conversation --

VICE CHAIR GOLD: Where are we trying to get to, Anne? I think part of this may be a lack of clarity on the Commission side as to what the purpose of this analysis is.

COMMISSIONER LAMPKIN: And I would say I think it's a hard question for me to answer, is what is the next analytic step, because I don't feel like we've had enough discussion about what we think and where we think the opportunities are. For me personally, my concern around this is less around recycling money kinds of increased FMAP implications, as much as the disincentives that this very allowable funding approach presents in delivery system reform. I mean, that's where my burn is, honestly. If we're interested in aligning financial incentives and buying quality and outcomes, if we have an environment where particular provider types' expectation is that a certain volume of dollars comes back to it because of a tax structure or because of a funding structure, that limits your ability to rebalance where services are coming from in your system and drive to value.

So what kind of policy options might there be if we live with these funding sources to address on the policy
side as a way to improve that dynamic?

CHAIR ROSENBAUM: Yes, another way of maybe saying it is given the nature of the inherent structure of the federal-state Medicaid financing relationship, what types of standards would you want related to delivery system reform, I mean, I think that some of the 1115 work that the administration has carried out over the past several years under the wonderful acronym DSRIP -- one of the worst I've ever heard. But I think that some of that is the beginning of an effort to try and deal with this question. You know, given our relationship, given the fact that there are two partners at the table, what kinds of indicators of quality or value or performance or whatever you want to say might Congress begin to think about, might the Secretary begin to think about, given the financing arrangements. And the natural tendency of those financing arrangements may be to pull in a direction away from a value-based purchasing system. What would be some countervailing steps that we might think about? And there, you know, it seems to me there's a fair amount going on in the world of demonstration programs, other programs, managed care programs, for how we are beginning to
articulate value in payment so that we might go down that avenue and come up with some indicators as opposed to sort of trying to deconstruct it from the financing perspective.

COMMISSIONER COHEN: I think I had an earlier point. I will combine it with the later thought that just came to me. I just think very worth noting a point in here that almost -- much of this additional contribution, not from state general revenues or whatever, is hospital related. Again, another potential sort of distortion with where we want the delivery system really to go. And I would say one thing that we could talk about, think about, explore, is around the managed care and supplemental payment connection, because it is a terrible disincentive for states to move away from fee-for-service payment when they lose UPL and other kinds of supplemental payments, and to figure out a way to say you've got a baseline, let's think about that baseline and how to get more value out of it rather than you want to do value-based payment and you lose your access to something that you as a state have depended on for a very long time.

CHAIR ROSENBAUM: Well, it's built into the taxing scheme of the state. It's part of its DNA. And I
think that, you know, it seems to be echoed somewhat around
the table that the real focus of the work is how do you,
given the financial relationship between the federal and
state governments and the inherent directions in which that
relationship can pull at the local service delivery level,
how do you build the system that can overcome some of those
natural tendencies? What kinds of performance measurement
structures do you use? What kinds of emphasis do you put
on your payment structures? So sort of taking the
situation from a revenue side as it lives and thinking
about what you do with it then.

Just to try and come back -- I really don't want
to leave Anne hanging like this, and I don't want to leave
staff hanging like this. I think what we're saying is that
if we take -- and please jump in and help me here. I think
if we take the three presentations we've heard now, you
know, how -- I'm going to put the DSH issue aside, because
I think that is a discrete activity that we can come back
to. So if we think about hospital supplemental payments
and then bookend it by the federal-state financial
relationship, we're saying -- I think the emerging sense of
the Commission is that, to the extent that the morning and
the afternoon presentations draw a link, our sense -- and I think we couldn't have gotten there without the presentation and without all the work that came leading up to this. But our sense is that linking the two discussions and essentially trying to offer solutions on both sides of the equation is not where we think the value of our contribution lies.

Where the value of our contribution lies is going back to essentially this morning's discussion about supplemental payment policy and realizing that there's a lot we don't know, so we may want to try and come up with an agenda that refines our knowledge about supplemental payments and what happens with them and where they go and what they do and how they're faring in a new world where we're moving more and more toward, you know, a capitation system that doesn't include supplemental payments. And that what we really want to focus on is how you could construct a policy that ensures that wherever states are setting their payment rules -- which they may do for all kinds of reasons, and they have a fair amount of autonomy in the statute to do so -- that the states are selecting from sort of a series of options that, in our view, get us
toward something that we loosely put under the banner of
value. In other words, that there is a direction we're all
moving and you're not just making payments to a provider to
make payments to a provider because the provider's always
been there. You're making payments to the provider in
order to strengthen its performance for the people it
serves.

And so that I think is where we want to be in
this vector here and not -- we want to be on the morning
side of the discussion and less on the afternoon side of
the discussion, where I think we're dealing more with
historic questions of taxation policy and federalism that
are tangentially related to Medicaid, but they're related
to every other social welfare question we could ask.

COMMISSIONER COHEN: I would just add to that, I
actually thought that was a really good summary, and I
think that orientation to start thinking about like what is
everything that we can do as a Commission, to start
thinking about every -- you know, every dollar having some
sort of value connection, and how you sort of get from
where you are now to there is a good direction.

I would also say every single conversation today
has centered around how impossible it is to have a policy discussion -- and we're not supposed to be having an enforcement discussion here. We're supposed to be having a policy discussion without information about provider-level supplemental payments. But we've made the recommendation before, but all of this comes back to that point. It is really hard to move forward in policy on these questions the way they're framed without that information, so just more emphasis on the need for that if you want to have a policy discussion about supplemental payment. The direction and how you execute on that direction to try and think about ways to make supplemental payments more value-oriented I think is the right one -- is the right question, but what are the analytic steps for the sort of policy directions that we can go on, I think we all need to brainstorm a little bit more.

COMMISSIONER DOUGLAS: So I don't want to be the naysayer. I completely agree on the fact that these supplemental payments have caused havoc with driving value. That being said, if too much of the focus is on just the value side, the entity -- seeing this, you know, on a state level, the entities that have been funding -- or have been
putting up the dollars might just not do it. And so you have a very tenuous situation here which gets back to the financing of, you know, whether it's an effective FMAP of whatever it was, 57 or 60, you know, whatever that is, you're not dealing with that fact.

And so just focusing on value, the providers, some of whom, you know, you're relying on to make this work, have very little focus on Medicaid, are going to walk away and the whole thing crumbles.

So we can't forget that. I'm not saying that we can't focus on this, but we at some point need to come back to the underlying financing and why it's been structured like this at a state level and why they've had to do this and why providers have been willing to step up. And if we don't keep that in mind, then value will be all for naught.

CHAIR ROSENBAUM: Well, for sure it's a very -- I mean, just as there are federal and state partners, you then end up with state and locality partners.

I have to say one of my reactions to today was that I don't think that the word "contribution" is the right word. There is the taxation or there's an intergovernmental transfer. It is not a contribution the
way, you know, you make a donation. It is discretionary to
a degree because a local entity, a local government could
decide to alter its taxation base and announce it's not
going to generate the local revenue, although I presume
state law, you know, might require it. And you certainly
could have providers resist a broad-based provider tax.

Now, I'm never quite sure what it is when it's a
public hospital district, whether at that point it's an IGT
or a tax. But be that as it may, I think you drive home
the point that what makes Medicaid so complicated is that
it's a cascade of complicated relationships. It is this
incredibly delicate balance at one level between the
federal and state governments, at another level between
states and their localities, states and their health care
providers. And how much you can incentivize Medicaid to
alter itself is certainly a question, but I will tell you,
I was just saying this to somebody the other day, when I
look at Medicaid 20 years ago and I look at Medicaid today,
it's dramatically different programs.

And so I think change comes, and it comes very
slowly, and part of it is because there's so much
collateral damage that could happen along the way. I think
we actually have a lot to learn from the DSRIP and 1115 demonstrations that are trying to do this. And that's, you know, a useful thing for us to plumb. And, clearly, it would be nice to know more about exactly how supplemental payments are put to work at a provider level, which we may or may not ever know.

We have time for public comment.

### PUBLIC COMMENT

* [No response.]

EXECUTIVE DIRECTOR SCHWARTZ: Nobody else has figured it out.

[Laughter.]

CHAIR ROSENBAUM: People are, like, "Ohh." When I looked at this agenda the other day, I said this is going to be a tough day.

Okay. Well, we are now on break.

* [Recess.]

CHAIR ROSENBAUM: All righty. We are coming down the home stretch here, and, of course, we've saved the best for last. We are up to Tab 7 now, which is the review of children's coverage recommendation papers, and Joanne will present an overview for us so that we can basically give
the MACPAC staff our feedback on what we'd like to see brought forward to us in December for what we anticipate will be a formal committee vote.

So, just to remind everybody, we are not voting today. The voting meeting is December. What we are doing today is expressing our preferences regarding what we'd like to see brought to us in December, based on all of the discussions we've had over the year or so.

### REVIEW OF CHILDREN’S COVERAGE RECOMMENDATION

PACKAGe: DRAFT SPECIFICATIONS

* MS. JEE: Okay. So this afternoon, we're returning to the Commission's work on children's coverage, really picking up where you all left off at the May meeting, and you will recall that in May, the discussion focused on some key components for a recommendation and several related decision points therein.

In May and in earlier months, your discussions have highlighted that any recommendation on children's coverage should address both the short-term issues for states and children by extending CHIP, but also a movement toward a longer-term vision in which there is a more seamless system of coverage for children and to provide
states with some options for doing that.

At the end of the May meeting, Commissioners, you asked staff to come back with you to today's meeting with a straw man proposal or something that we're also calling "draft specifications" that are built around the inputs that you've provided.

So, today, we are going to review with you the staff straw man, which includes four elements, and we really look forward to your comments and inputs onto each of those elements. So, based on your conversations, staff thought that you really seemed to coalesce around four key areas. The first is extending CHIP funding; the second, permitting optional CHIP-funded exchange subsidies. The third is broadening state innovation waivers, and the fourth is extending the expiring provisions that often ride along with CHIP.

During the presentation, I am going to focus really on the design specifications for these elements, but your meeting materials include some of the rationale that go beyond that, and, of course, those are very important. If you have comments on the elements and the specs themselves as well as the rationale, we'd appreciate
hearing from you on those today. And this is really just
our best attempt to capture what we think we've heard you
say so far.

After going over the recommendation straw man or
the draft specs, we're going to talk very quickly about
what the next steps are.

So the first element is really the foundation of
the recommendations package, and that's an extension of
CHIP funding. Commissioners, you've discussed extending
funding anywhere between two and ten years, but you really
seem to coalesce around something in the middle. So the
straw man has a CHIP funding extension for five years,
which is essentially the midpoint.

Moving on to the maintenance of effort, the
strawman maintains current law, and that permits the
maintenance of effort to expire after fiscal year 2019.
Based on your conversation regarding the MOE, we think this
is where you are headed over the course of your
discussions.

Moving on to the next part, which is the CHIP
matching rate, you have previously discussed the 23
percentage point differential to the CHIP-enhanced match,
and that it doesn't really relate to any increased enrollment in children's coverage or any improvements to that coverage, but that it does cause the states to spend down their allotments more quickly.

You've also noted that states would face some difficulty if that CHIP matching rate and that differential were to change suddenly.

So the draft specifications include a phase-out of the 23 percentage point differential and the CHIP matching rate by fiscal year 2020.

Your materials lay out an example of how a phase-out might work, so your reactions to that would also be useful.

And, finally, also related to the CHIP matching rate, the draft specs include one more item, and that is adding a 5 percentage point differential to the enhanced CHIP match rate for states with CHIP eligibility at or above 250 percent of the federal poverty level.

In past meetings, Commissioners, you have discussed that children around this income range experience vulnerabilities to lack of coverage or high out-of-pocket cost, similar to children with lower income.
The second element is optional CHIP-funded exchange subsidies. This element would give states a new option for using CHIP funds to help CHIP-eligible children purchase exchange coverage. There is an important decision point for you here that relates to the federal exchange subsidies, but I am going to come back to that after I lay out the rest of the framework for this option.

On eligibility, states would determine eligibility up to their CHIP income eligibility levels, and on affordability, this is something that, Commissioners, you have talked extensively about. And given the concerns related to affordability of coverage on the exchange, the draft specifications would apply the CHIP standard that limits family out-of-pocket spending for premiums and cost sharing to 5 percent of family income, and the draft specifications would also require that the exchange plans purchased with the CHIP subsidies have an actuarial value that is substantially similar to CHIP, which is on average about 98 percent.

On benefits, the draft specifications lay out that states taking up this option would need to ensure that children are provided benefits that meet the state CHIP
coverage levels, and that would include oral health services.

Commissioners, you have talked a lot about cost effectiveness in the context of CHIP and Medicaid. You have noted the difficulty that states have experiences with the cost-effectiveness test. So the draft specs focus on ensuring that the states' approach to using these subsidies would promote efficiency and children's coverage.

The draft specifications also propose a requirement that states provide public notice and an opportunity for stakeholder comment prior to their submitting a state plan amendment to CMS.

And, finally, the straw man calls for a secretarial evaluation of the subsidies to shed light on the impact of these subsidies on things such as coverage, access to care, affordability, and network adequacy.

So here is where I wanted to return to that decision point that I provided to you a couple of slides ago, and the question before you is whether CHIP-eligible children who would receive the CHIP-financed exchange subsidies, whether they would also receive the federal exchange subsidies for premiums and cost sharing, so in
addition to those subsidies, or if they would get the CHI-f
anced subsidies without the federal exchange subsidies.

As a reminder, individuals with incomes between
100 to 400 percent of federal poverty, of the federal
poverty level, are eligible for the federal premium
subsidies on the exchange and those with incomes between
100 and 250 percent of the FPL are eligible for cost-
sharing subsidies if they purchase a Silver Level Plan.

If the CHIP subsidies are provided in addition to
the federal exchange subsidies, the federal subsidies would
be based on the current exchange rules. The CHIP subsidies
would pay for the child's portion of the exchange premium.

CHIP subsidies would also be used to provide
wraparound. Remember we talked about applying the CHIP-
level protections. So it would be used to provide any
wraparound on cost sharing and to help bring the exchange
plan AV level up to the CHIP level.

I do want to note that under this option, state
CHIP spending would be reduced significantly, and federal
spending would be increased. And it also would be more
complex to administer relative to the option in which the
CHIP subsidies are provided without the exchange subsidies.
And, if the CHIP subsidies are provided without the exchange subsidies, the CHIP funds would also be used to provide any needed wraparound coverage.

CHAIR ROSENBAUM: Just to clarify, within this option, we have a choice to make --

MS. JEE: Yes.

CHAIR ROSENBAUM: -- about whether to recommend at some point maybe a financing arrangement that would essentially -- I hate the word, but I'll use it -- "blend" the federal premium tax credits with the increment, the increment to bring everything up to CHIP levels, coming out of state CHIP funds, or to allow the option to essentially merge a market, but using only state CHIP funds to do it.

MS. JEE: Right. So, in the first option, there is the federal subsidy and a CHIP subsidy, and in the second option, it's just the CHIP subsidy.

CHAIR ROSENBAUM: And I should just note -- and we'll talk about this more, I know -- that even simply allowing the states to merge their markets and buy exchange plans using CHIP funds is an important policy discussion because the rules for exchange plans and CHIP plans are not exactly the same.
MS. JEE: Right. So that's perhaps the first-order question.

CHAIR ROSENBAUM: Right, exactly.

MS. JEE: Okay. So, moving on to the next element of the straw man, which is broadening state innovation waivers, Commissioners, you've talked a lot about a longer-term vision for children's coverage, and the hallmark of that would be greater seamlessness across those sources of coverage, particularly with respect to affordability and benefits.

A new optional waiver would provide an opportunity for states to take some steps toward that vision and would support their efforts to integrate Medicaid, CHIP, and exchange coverage for states that would want to do that. Again, this would be an option.

The draft specifications or the straw man would also direct the Secretary of HHS to establish some state participation criteria to identify states that could participate in this, as well as develop a waiver template to help simplify the application process for states.

States pursuing this option would also need to demonstrate that their waivers would not result in losses
of children's coverage rates, and for those children who are under 133 percent of FPL, the Medicaid rules would apply.

Okay. And just wrapping up with the waivers, federal funding for the waivers would come from Medicaid, CHIP, and exchange funds that states would have spent of children's coverage, absent the waiver. And, as with the subsidies, there would be a requirement for an evaluation of this approach.

The last element of the draft specs or straw man is the extension of expiring provisions that have been renewed along with CHIP funding in years past. So the straw man would extend through fiscal year 2022. Authority for states to use express line eligibility to determine eligibility for children in Medicaid and CHIP; would extend funding for outreach and enrollment grants; and would extend funding for the Pediatric Quality Measures Program as well as for childhood obesity demonstration projects.

The expiring provisions is the last of the four elements of the straw man that we have developed for you. Before we move on to the slide on next steps, I just wanted to let you know that we did receive a preliminary cost
estimate on the package, and that estimate has the entire package coming in at about -- as increasing federal spending by about 3.4- to $3.7 billion over five years, so that would be the range.

And a couple caveats that are important to that cost estimate, first is that the estimates would really depend on -- could be affected by whatever legislative language is ultimately developed by the Congress around any funding of CHIP, and a second caveat is that the estimate does not account for the new benefits notice and parameters for 2018 issued by CMS, which includes proposed age rating factors for children. And that would change premiums in the exchange for children. So that is not yet factored into the cost estimate, and CBO generally does not factor in proposed rules. And we expect that once those rules are finalized, if it retains the child age rating factors, that we might see that reflected in the baseline in March.

Okay. So, to just quickly go over next steps, based on the conversation that you all have here today, staff will take your feedback and input to prepare draft recommendation language for your consideration in October, and that language would go over the specs as well as cover
the rationale. So, in October, you would review that language and again provide us any feedback, and in December, Commissioners will review the revised language one more time and make sure that we've captured everything correctly. And then we anticipate a vote at that point.

Following that, we would publish recommendations with the accompanying rationale as well as any other text needed to sort of set up the recommendation in advance of the March 2017 report.

So that's the run-through of the specs. It's a lot. If something doesn't seem quite right yet, then please provide us as much specificity in your comments as possible, and that will help us take the next step.

CHAIR ROSENBAUM: So the floor is open. Peter, do you want to start us?

COMMISSIONER SZILAGYI: Sure.

CHAIR ROSENBAUM: Sheldon, did you --

COMMISSIONER SZILAGYI: First of all, Joanne, this is an excellent summary of our May discussion, and I think it really takes us to the next step. I think it summarizes very well kind of the dual sort of streams that we had in May, which is both to maintain a very effective
program and to provide states with options and flexibility in the new marketplace. And we were kind of dancing around both of those themes, and I think these four elements very nicely both summarize our discussion and kind of bring us toward a recommendation.

So, as you were talking, I was thinking of some context. We've spent a lot of time at these sessions about programs for which we have little data to evaluate. This is one of those programs for which there is a lot of data. It's been evaluated. It's highly effective. It's a vulnerable population. It's a low-income population. Studies over and over again have shown improvements in access, quality, and outcomes, and that's hard to do in the medical field now. So, to me, personally --

CHAIR ROSENBAUM: You led the way.

COMMISSIONER SZILAGYI: Well, many states.

To me, personally, reversing the gains from CHIP is unacceptable, and so I think -- I love the word you used, which is "foundation." To me, the bedrock of this four-element specification is continuing the current CHIP four, five years, and we can talk about that. But I think that's sort of the foundation and the bedrock.
I think the staff has done outstanding studies to demonstrate that currently in the exchange coverage, the plans have very poor actuarial value, poor benefit structure, and it won't work for children. They just won't work, so we have to do something to improve that.

The first part, I do support extending CHIP. We did talk about two to ten years, and five years seems like a reasonable compromise. I would be uncomfortable going below five years, and we may want to have a discussion about should it be longer than five years here. I just think that states need a couple years to ramp up or ramp down, and sort of five years would be a minimum.

Having thought since May, I am worried about dropping the maintenance of effort in 2019, and I personally would tie that to the length of extension of CHIP, but we may want to have a discussions around the table about that. But my thinking now would be to continue the maintenance of effort for the five years.

The matching rate, there wasn't great evidence to show that enrollment increased because of the matching, so I think this concept of sort of a step down, a phase down is a reasonable approach to me.
And the third component under this first element about adding a 5 percent sort of incentive to increase in the FMAP to provide states 5 percent more if they go up to at least 250 percent of the poverty level follows the data very well. I mean, really, kids between 200 and 250 percent of the poverty level are not that different in terms of their unmet needs, their needs, their diseases, than kids who are lower than 200 percent. So I think 250 percent seems like a reasonable level. I personally might have picked 300 percent, but we around the table then talked about 250 to 300 percent. I'm okay with that.

So that's the first element, extending CHIP. The second element is using CHIP funds to purchase exchange coverage, and I agree with this policy option. I suspect there is going to be operational challenges to doing this, but I really think this heads us toward what I think many people around the table are interested in, which is a long-term plan in the exchange that meets the needs of the children, and the CHIP plans are much closer to meeting the CHIP needs of children than any current exchange option.

So I personally would favor both the federal --
that was the first option in which we use federal exchange
subsidies in addition to the CHIP subsidies. I know there
are administrative challenges in doing that, but I think it
gives states the option. We may see great creativity
coming out of states, and I would favor that.

And, by the way, the cost estimates weren't that
high. For a large population, the 3.4- to $3.7 billion was
not per year. It was over five years, so $600 million per
year for a very large population does not seem that high to
me.

The third component broadened -- is the
innovation waivers, which I think is very important. I
won't talk about it, but I think it's really very
important. And I really like how you didn't limit
suggesting a certain number of states or anything like
that. We left it open, and I would favor that.

And the fourth option, which is to extend the
specific provisions -- there's actually very good evidence
that express lane works and that outreach works to increase
enrollment. So those are very evidence-based.

And then the other components are quality
measures, and I would support that too.
So, overall, I think it's a really good summary. I think it will lead us to a recommendation. The bedrock of this is to extend CHIP for, I would say, at least five years.

CHAIR ROSENBAUM: Before I call on Andy and Gustavo and anybody else who has a comment to make, Joanne, just because not everybody who is on the Commission necessarily thinks about child health all the time, can you just remind people what the maintenance of effort provision requires?

MS. JEE: So the maintenance of effort provision requires states to maintain their children's eligibility levels in Medicaid and CHIP at the levels that they had at the time of the ACA passage through fiscal year 2019. So states can't reduce their eligibility. So, if I'm a state and I have my CHIP eligibility level at 200 percent, I may not reduce my eligibility level to 150 or 185.

CHAIR ROSENBAUM: And if you had Medicaid up to, say, 150 and CHIP then another 100 percentage points over that, you can go higher, certainly, but you can't go lower on either side?

MS. JEE: Yes. Yes.
CHAIR ROSENBAUM: Andy.

COMMISSIONER COHEN: Thanks so much, Joanne.

This has been a marathon, not a sprint, and you've been terrific. And your analysis and your ability to sort of move us to the next level at each phase has been very impressive, so thank you.

A couple of big-picture points, and I'll sort of go at it in the same way that Peter did first. In terms of the justification and the big picture, I just don't want to give short shrift to like the really big picture here, which is we as a Commission, just like Congress did in the 1990s did when it created CHIP, are making a statement that children's coverage should be different than adult coverage, that there is a need for different ways of thinking about cost sharing, because children don't work and families have more than one child. And for all sorts of reasons, cost sharing might need a different kind of look.

So much of children's health care is about -- not about they're not a high-cost population. It's about prevention, prevention, prevention, and is so critical, and that also tends to be somewhat different than where we are.
with adults where a lot of sort of the bread and butter of health care is around chronic care disease management. This is about prevention, and we have made some statements about not going backwards with respect to coverage.

So I think that really needs to -- children are different from adults in terms of their needs, in terms of the commitments that Congress has made to them a long time ago, and I think we are sort of saying something about that too. So I don't want to lose that in our justification. We are sort of going out there with they are different.

So I am also comfortable with the five-year extension. I think five years is a reasonable amount of time and a very fair place to land between two and ten years, and I think based on our past recommendation, we now have some more understanding that these are major programs and major decisions in a health care system that is very much in flux. And nothing is going to change in two years, and yet we want to set a course and a direction, so I like five very much, and I'm very comfortable with that.

Like Peter, coming back to our big picture, I have some discomfort around dropping the maintenance of effort, and that may have cost implications. I have no
idea what kind of assumptions CBO makes about that, but if one of our principles is to not go backward with respect to children's coverage -- and, presumably, the MOE was created in the first place -- it was such a long one, a nine-year MOE. That's a long time. It really went a lot to there was going to be a lot of uncertainty and need for a period of stabilization after a major reform, before it was going to make sense for some of these issues to be reevaluated. And I think we are still in a period of substantial inability with respect to the implementation of the ACA and what the markets look like, and I think this would be a difficult time to move back on the maintenance of effort, especially in the context of this commitment about not wanting to go substantially backwards for kids.

And I don't think it is -- I mean, children are -- CHIP is not a terribly expensive program for states, certainly not compared to some other health care programs, and I just think it is not a huge burden on them. But I know it's a very controversial point, and we will discuss it, but I have become increasingly uncomfortable about that.

Everything else, I would say I either agree with

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Peter or agree with what's in the draft. I want to get to the issue around the subsidies, the CHIP-financed subsidies, the option for states, and, again, we spent a lot of time trying to get our heads around what this option is going to look like, but I just want to put it in context. The big picture here is we're saying that CHIP should be extended for five years. We want to set a course and a direction for where we think CHIP might go and start by providing states with an option to go there on their own if they're interested. It's taken a lot of our mental time space and analysis, but it is just an option.

I don't think the question is really the right question of whether or not there should be CHIP and federal subsidies sort of blended or combined or not. I think the answer -- the question should be around how much money do you need to provide the kind of subsidies that we think we need to get children's coverage to the level that we want to in the exchange, and then what should the contribution of sort of the state and federal government as compared to where they are today are. And I don't think we have the analysis to answer that question right now.
And so I would say I don't want to give an answer to it should be -- there should be federal subsidies or there shouldn't. We understand having federal and state things combined adds complexity. I don't think we have to work out every single detail to give a directional recommendation, and I would say that we should not -- I would not prefer to vote on the answer to that question without more analysis about how it adds up from the perspective of how much subsidy we can buy for kids in either way. So I will leave it there.

CHAIR ROSENBAUM: Okay.

COMMISSIONER CRUZ: Joanne, thank you so much. Thank you so much not only for the presentation and for summarizing all the discussion, but for sort of logically taking us from all the discussions that we have had for the last year. I mean, it's a perfect example of how ideally policy development should be from analysis of existing data to what is happening to where we're going. And I think this is the product of all those conversations that we have had for the past few years, so my kudos to all the staff and especially to Joanne.

I think in fairness this is a great summary that
also for a better sort of substantial understanding of this requires a reading of the material that you have in, because there's a lot more than is just on the slides.

In terms of the specific of it, I do agree with Peter and Andy in the funding for five years. I think that is reasonable, and I think there is precedent for it.

And we did not actually coordinate this, I should say, but I have also my hesitation about the dropping of the maintenance of effort, especially when we are sort of introducing many changes that the states are going to have their plate full in terms of what should we do. Are we going to buy exchanges? Are we going to keep CHIP? Are we going to submit a waiver for this? And the eligibility of these kids may be at peril when they are considering all of these options.

I think the federal evaluation is key, and I think it's excellent that we are asking for the Secretary to assess the intergovernmental coverage and access to care, and especially in terms of coverage levels and benefits.

I've said before I do not -- I have my -- not my hesitation in terms of the using of the federal exchange
subsidies, but understanding better what that means and what is it that we are trying to achieve. We understand -- and this is a question I have. If we suggest or recommend for the states to be able to use the federal exchange subsidies to cover CHIP, that requires a change in the IRS Code, doesn't it, in the Tax Code?

MS. JEE: Yeah.

COMMISSIONER CRUZ: Because that's the --

MS. JEE: Yeah, it would certainly require some sort of legal change to enable that to happen.

COMMISSIONER CRUZ: It's a little bit more complicated. So I think that requires a little bit more discussion before we move forward with that.

CHAIR ROSENBAUM: Just to be clear, everything we recommend will require legal change. So you shouldn't be worried that the Internal Revenue Code is somehow scarier than the Social Security Act.

COMMISSIONER CRUZ: Okay.

[Laughter.]

COMMISSIONER CRUZ: Well, you have to be cautious.

Also, I want to also emphasize -- and I'm glad
that it's here -- beyond the federal evaluation, as we have talked before, the issue of assuring network adequacy is really very important in terms of we don't want to go back on how -- all the achievements of CHIP, and that has been one of the achievements sort of assuring as much as they can proper network adequacy.

I have another question, and this is my final question. Are we also suggesting that within the exchanges, both federal and state, there is the possibility that the exchanges create a new program or a subset of a program that exists to cover CHIP-eligible children?

CHAIR ROSENBAUM: So are you asking whether this option would be an option regardless of whether a state uses the state or federal exchange?

COMMISSIONER CRUZ: That's part of the question. And the other question is: Can Blue Cross and Blue Shield create a subprogram within their exchange program just to cover these children that will be different in terms of benefits and stuff than the regular program?

MS. JEE: So as far as staff thinking goes, you know, it really would use the exchanges. So whether it is state-based or whether it is the federal exchanges, there
are different issues for states that would take up the option if they are -- if they have a federally run exchange.

In terms of whether an issuer could create another product -- I think that's maybe what you're saying -- for the CHIP-eligible children, I think that that certainly could be a possibility. Right now, the exchanges -- the exchange rules govern, you know, the benefits on the EHBs as well as the actuarial value of the plans. So if a plan were to be -- if a plan wanted to offer something different with a different sort of cost-sharing structure than what they already -- I'm sorry. If an issuer wanted to offer a product with a cost-sharing structure different than what they already offer, they would still need to sort of work within the actuarial value requirements of the exchange.

CHAIR ROSENBAUM: The assumption here would be any plan sold on the exchange, as Joanne notes, would have to meet qualified health plan requirements.

MS. JEE: Exactly.

CHAIR ROSENBAUM: But what we are essentially saying is that in consideration for giving states some more
flexibility to shape their markets, you know, lots and lots of discussions over the past several years now about how to create a more stable insurance market. So if a state wanted to test potentially a different approach to its insurance markets, it could do so on the understanding that the plans it was buying for children in a more unified market met CHIP requirements.

So what we've been able to discern over several years of study -- and stop me if I'm wrong, Peter, or anybody, Andy, anybody -- is that in a nutshell the benefit classes that have to be covered in qualified health plans are not different. And, in fact, there's an argument to be made that they're actually a broader set of benefit classes than one finds in the CHIP statute. I'm not worried about what the states might do with that for the moment.

Where there's a dramatic difference is the actuarial value. So I am assuming that if we made recommendations about a new flexibility option but an option that would require states to reflect certain CHIP expectations, that the crucial issue is the actuarial value of the benefit classes. There well could be other places where if you lined up the standards for the sale of CHIP
plans federally and the standards for the sale of CHIP
plans, qualified health plans federally, there might be
other differences. But where there might be even more
differences is a state's own standards. You know, a state
may have extensive regulation of the sale of a CHIP plan
that doesn't apply to the sale of its exchange plans.

And so this would have to be undertaken on the
understanding that probably the Secretary of HHS be given
authority to work with states that wanted to do this --

VICE CHAIR GOLD: That's the innovation --

CHAIR ROSENBAUM: Yeah, exactly. To align their
existing CHIP policies with their exchange policies. But, quite frankly, this is the irony. I'm putting on my
insurance lawyer hat. To the extent that there are sizable
differences, a lot of those differences are a matter of
state law and not federal law. So if a state wanted to go
this route, it would basically be saying what I'd like to
do is come up with a more unified set of pediatric policy
expectations that are at least as good as CHIP. You might
have a sense of lifting -- lifting the boats in the
exchange market.

COMMISSIONER CRUZ: Yes, that would be a benefit
[off microphone].

CHAIR ROSENBAUM: Yeah.

COMMISSIONER CARTE: Thank you. As others have noted, I think that a lot of uncertainty has entered into the exchanges since we had our May discussion, so I think it would be appropriate to revisit the maintenance of effort. It should at least be comparable to the duration of the extension, and I think that the five-year extension sounds reasonable. Hopefully we would know where -- that we're in a better place by then.

Where we mention under the optional considerations that public notice would have to be given, I guess I would like to make a special plea to the Commission. I've mentioned it maybe in passing before, but more formally to say that public notice usually involves 30 days, and the CHIP directors as well as the Medicaid officials who administer CHIP programs, after our experience with implementing the stairstep transition, and that really this takes about a year's time. There are the budgetary considerations, the considerations of where children are in the course of treatment, and many other things, that this would be a one-year advance declaration
that the state intends to make, you know, this transition. And that would be most helpful, as well as, you know, CHIP -- the states and the CHIP programs now have twice had to go through this kind of hyper-uncertainty, both through the reauthorization back in 2009 and again, you know, last year. And while everybody seems to take it for granted that in all likelihood it will continue, it's very difficult for state officials to be in that place.

And then, lastly, I would just mention that I'm glad that we are all together on the consideration of the expiring provisions for CHIP that cover express lane eligibility and outreach and the pediatric quality measures and the obesity demonstration projects. I would hope, though, that we could say -- give more emphasis -- I think the pediatric quality measures, when that was written into CHIPRA, was probably in deference or emphasizing that the children's pediatric core measures at that time had come up and that we might more broadly emphasize that those funds could be used for value-based projects that -- and medical home, whatever, but a little bit beyond just pediatric quality. And that's important to me because pediatric quality I think still is -- it gets short shrift. You
know, the focus, as, Andy, your paper in New York by Bailit shows that we're really not giving sufficient attention to what pediatric quality means currently.

COMMISSIONER THOMPSON: Well, first of all, thank you, and I agree with much of what has been said particularly about the formulation of the straw man, and particularly around extending CHIP. I could have gone for more than five years, too, partly because I think if we are really serious about thinking that we want to support state innovation activities, that really a five-year program does not give a lot of time for people to work on designing and implementing and operating and evaluating a program like that. But I also recognize that a five-year period is a pretty typical window here, so I can buy that.

I guess I will be in the minority in speaking of the straw man's approach to retaining current law with respect to MOE. And my argument for that is really tied up in kind of the package of provisions that we have tried to arrange here, where we phase down over a period of years the 23 percent point differential and provide a further incentive at the end of that period for states to maintain or expand CHIP eligibility.
You know, it's my fervent hope that states would not reduce CHIP eligibility, so I think the question, though, is: Whose decision should that be? And I think that the combination of phasing down and getting states used to over a period of several years a lower match rate and providing that additional incentive will position states to make a reasonable choice for them going forward. And for all of the reasons that we have discussed that CHIP is so important, because it has such support, there's a lot of evidence about it works and it produces outcomes, I would hope that it could stand on its own in a state at the end of the expiration of MOE and make the argument for itself, and a state would then evaluate that evidence and information and decide to continue the program and to continue to strengthen the program. But I would be uncomfortable with a federal requirement around MOE which, appreciating all of the things that we've said about why we want to see CHIP maintain current eligibility levels or even expand and why we're concerned about continued instability around the insurance market, at some point I think -- and this has been a long MOE period -- I think that MOEs should be relieved from the states for them to
take in all of the requisite information and make some of those decisions for themselves based on their markets and based on their populations.

COMMISSIONER BURWELL: I was just going to follow up [off microphone] --

CHAIR ROSENBAUM: Mic.

COMMISSIONER BURWELL: -- the MOE provision and the declining matching rate. In the declining matching rate, does that mean that the amount of federal funding we estimate will decline every year for five years?

CHAIR ROSENBAUM: It was raised very high, and so what we're recommending is that -- not recommending. What we are considering at this point is recommending that it come back down to the normal enhanced CHIP rate.

COMMISSIONER BURWELL: My question was: What is the impact on the CBO estimates of that reduction?

MS. JEE: So the CBO estimates account for that, the phase-out of the 23 percentage point --

COMMISSIONER THOMPSON: And it's my assumption that most of the costs in the CBO estimates are about -- they would have scored in the baseline no more enhanced rate at all, right? Is most of the cost in the CBO
estimate associated with the fact that we are phasing out
rather than outright eliminating the 23 percent match,
increased match?

MS. JEE: I mean, to phase out the 23 percentage
point bump would save money.

COMMISSIONER THOMPSON: Because they have in the
baseline that in perpetuity?

MS. JEE: No.

COMMISSIONER THOMPSON: That's what I'm saying.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. If you kept
it passed the point at which it expires now, it costs
money. If you get rid of it immediately, it saves money.
And if you ratchet it down, it's somewhere in between.

What we can't tell you is of this estimate, how much of it
is attributable to what we're proposing. I think we saw an
earlier estimate. That if you just allowed it to expire --
and I can't remember what it was in combination with -- the
whole thing became a saver. But it was a much more narrow
question we were asking at that point. So there is cost
associated with the phase-down and keeping it at that five
percentage point differential.

COMMISSIONER COHEN: Can you just remind us long
it's been? It's been in place for one year, the 23 percent bump? Is it currently in place?

MS. JEE: Yes. 2016.

COMMISSIONER BURWELL: I guess I will join the minority of Penny in terms of allowing the MOE to expire. I do think -- I mean, and I agree it's a matter of a state decision, and I would hope that they would continue, you know, without that federal requirement.

I guess I'm also somewhat skeptical -- this is nickels and dimes -- about extending the funding of pediatric quality measures, $10 million a year for another five years. I think we ought to be able to develop measures with $20 million.

In regard to developing value-based purchasing with those quality measures, I think that is something that is happening in the mainstream in development of new payment models already. I don't think additional funding is needed for that.

COMMISSIONER COHEN: With all due respect, not so much for kids. In all population, yes. Not for kids.

CHAIR ROSENBAUM: So the other point is -- Joanne, I don't know if you can shed light on this, and
maybe Penny, from your past, if you can -- and that is the money is not just for the process of developing the measure. I assume that the money -- oh, Sharon, of course, you can too -- the money is for the act of actually applying the measures, collecting the data, evaluating the results, making refinements. I assume it's a sort of an ongoing performance measurement improvement system, really, not just experimental measurement.

COMMISSIONER BURWELL: I'm willing to be talked out of that.

[Laughter.]

CHAIR ROSENBAUM: I wanted to make sure that --

COMMISSIONER SZILAGYI: That's correct. The AHRQ spent the money to develop the measures and this is really for the implementation and trying to cycle back to improve quality.

VICE CHAIR GOLD: Peter, if they didn't have the funding, would there be a risk that we wouldn't have uniform measures across the state?

COMMISSIONER SZILAGYI: Sharon would know, but I thought some of this money was used for the IT systems and for sort of just administrative and all the infrastructure
type of work to use the measures. That's what I thought but I may be incorrect.

EXECUTIVE DIRECTOR SCHWARTZ: I think it's fair to say that they're not uniform now. I mean, the states' reporting of the pediatric quality measures still leaves a lot to be desired.

COMMISSIONER BURWELL: And are these quality measures specific to the CHIP population, or are they specific to Medicaid children?

COMMISSIONER CARTE: To Medicaid.

COMMISSIONER SZILAGYI: Low-income children.

COMMISSIONER CARTE: And they're HEDIS measures, by and large.

CHAIR ROSENBAUM: And the reporting -- I was looking at one of the reports. I don't look at these things very often but I was looking at one of the reports and it was quite -- I mean, a lot of states were reporting a lot of measures at this point. So it's gotten much better, I would say, over the past three or four years.

I have Brian and then Stacey here, and then -- [Speaking off microphone].

COMMISSIONER GORTON: Yeah, really. So with
respect to duration I will own that I was leaning towards the shorter end of the spectrum, and largely because of the argument -- I didn't want to just sort of be kicking the can down the road and letting things drift, and I was not initially thinking that we needed a whole five years in order to move the ball.

But I am moved by the arguments that have been made about how slowly this particular ship will turn, and so I'm okay with five. If we've gotten much more than five then I would be far more resistant than I am now.

With respect to maintenance of effort, I'm where the folks on this side of the table are.

[Laughter.]

COMMISSIONER GORTON: Or at least some of us.

You know, I don't see any reason to extend that and I would just add another piece of it. We tend to focus maintenance of effort conversations around what we think are deficiencies of states at the low end. If we actually expect states who have high levels of eligibility to be able to put this in place in some sort of new merged marketplace, you may have to move people out of Medicaid, out of CHIP, into a qualified plan, and the current
language around maintenance of effort, as I understand it, and I'm not as deeply steeped as you all are, I think that would form a barrier.

And so I'm inclined, overall, to let it stop, but if it doesn't get stopped there needs to be some way that the states can get credit. As long as they're providing coverage to those bands of eligibility, to a qualified children's health plan, then that should -- they ought to get some credit for that, although, again, I would overall let it stop.

I'm feeling a little more draconian, particularly because it could help us turn this into a saver around the 23-point bump. I'm not the expert here but you all have said it didn't work. And I don't know why you would persist in phasing out a huge chunk of money that when in with the idea that it would do something that it doesn't do. And I understand people are spending it for other stuff. You know, it folds. But, you know, was that really the purpose?

And so I guess me, personally, I would be inclined to dial that down pretty quickly -- maybe not immediately because that's a rate shock to states, but, you
know, they're doing their budgets year by year and I don't know that necessarily it needs to be until 2020 to figure out how to live with a lower rate. I don't have a problem with continuing 5 percentage point piece.

With respect to the subsidies, I guess I don't think we need to decide that here. I think we should include it in the recommendation as an option for the states, which the secretary will figure out how to effectuate, and the states will figure out what they want to do, and there will be, you know, an innovation waiver or a state plan amendment, or some other authority that gets negotiated, and the states will do that. And you're going to have to figure out -- because in this sort of new merged marketplace you're also going to have to factor societal into it.

So I think it could be somewhat complicated but I don't think we have to solve for that here. The point is that what we are creating is flexibility for the states to try and deal with children the way they have dealt with the rest of their health care marketplaces, in a way which is responsible, but which gives them some flexibility.

So I would be inclined -- I know Andy said she
didn't want to vote on this -- I would be inclined to say
we ought to include both of these options now, from the
get-go, and then leave it to the regulators and the state
officials to figure out to implement it.

With respect to the additional -- I'm having
trouble reading this whole thing. Oh, that's the wrong
page. That's why.

Innovation waivers, I think, is a great idea.

Again, you know, I think it may involve more than just
Medicaid, and so we need to make sure the secretary has the
flexibility to deal with that.

Expiring provisions, I'm assured by my friends on
the Commission who are experts in CHIP that these are all
good things and useful expenditures of federal funds, and
so I'm happy to have them continue.

COMMISSIONER LAMPKIN: To weigh in on some of the
parameters and the straw man, with respect to the extension
others have made a very eloquent argument for that. I'm
completely on board there.

With respect to the duration of the extension, I
find Penny's comments about demonstrations and how long
they take to be persuasive, and so if we think we are in a
position where we may be recommending those middle two
d Pieces, I think -- the exchange and the innovation waiver
those may be arguments for being higher than five. I
agree, I think, with Peter, who said five should be the
minimum, that that makes sense. But I could see seven or
eight, also, especially if we wanted to push the
demonstration side of this, for the reasons that Penny
noted.

With respect to the exchange -- oh, the MOE. I'm
here with let's give the states who have a budget
responsibility the opportunity to design their program,
especially if we're not maintaining the 23 percent, then
they should -- the MOE should expire. If we feel that the
uncertainty around the exchange is so worrisome that we
need to maintain the MOE, then maybe we have some
obligation around maintaining the enhanced FMAP, but that
is a more expensive option. But that seems, from a state
budget perspective, to be the fair thing.

I am curious about the 5 percent long term. If
we let the MOE expire, we ramp down the enhanced FMAP, and
we go with the 5 percent, this is something that I don't
think many people have commented on. Is 5 percent at 250
the sweet spot and we're already there, we don't need to discuss that further? Is there a two-tier approach that makes sense -- 5 percent at 250, 10 percent at -- or some mix of 10 percent at 250, 5 percent at 300, or some other combination that is worth discussing, or are we just -- we landed in the right spot right away.

CHAIR ROSENBAUM: [Off microphone] -- the 5 percentage point number is an incentive, and if so, what is the frame of reference.

COMMISSIONER LAMPKIN: Yeah. Exactly. Is that really where -- is that the right place? I don't know the answer. I just -- I'm surprised we haven't discussed that aspect more.

And then on the exchange question, this is appealing to me if we are talking about giving the states an opportunity to stand up like a super-platinum, cost-sharing, child-only plan on the exchange, or bring that CHIP population to help that thing be -- health insurers want to provide that product, because here's the CHIP population to help form the risk pool for it, and provide that opportunity through children who are not CHIP-eligible to buy and get a federal subsidy if they're eligible for
one, above the CHIP level. That's very appealing, if that's
where we're going there, and that's why, to me, to have
that stable risk pool and the opportunity for the higher-
income kids.

And the innovation waiver for similar ways, to
give states the place for those to merge.

So all that, in general, sounds good to me.

CHAIR ROSENBAUM: I don't want to put Leanna on
the spot but I'd really love to hear from you. So we have
people who live these programs as administrators, or who
have lived these programs as administrators, but you've
lived the program as a family that benefits from them.

So what I'd like to know from you is, you know,
if you were a queen, or just an influential MACPAC
commissioner, on this maintenance of effort issue -- so we
either, you know, it's 2019 and states are free, maybe, to
make their own decisions, because the MOE doesn't continue
after that date and they can drop down their Medicaid
eligibility, drop down their CHIP eligibility. We have had
one state, you know, make very significant changes, came
back into the CHIP program. And then, you know, on the
other side of the coin is the issue of not wanting to --
you know, not wanting to open that door.

So I'm curious where you are on this.

COMMISSIONER GEORGE: Well, I'm probably more or less on the fence but leaning towards letting it expire in 2019. It sounds like it's been an effective MOE for the last almost 10 years at that point, which is a long time for states not to have the ability to really tweak the programs and stuff, in accordance to what the market, the economy, and stuff like that is at that time.

But, of course, I think, you know, as Penny alluded to earlier, extending the MOE but dropping the -- what was it called? -- the enhanced match rate at the same time would not be a good thing either because, I mean, like I imagine a 25 percent drop in my income, or having a 25 percent increase in my expenditures would be -- for most of our states are all on balanced budget amendments and stuff like that, it would be hard.

CHAIR ROSENBAUM: Yeah. You know, what I was thinking as we've been having this discussion was the MOE essentially takes a snapshot of what your programs look like, in 2010, and said this is your program. And I'm wondering whether one possible thing to think through is an
MOE that picks up on the upper limit, okay. And, you know, if your highest eligibility limit for your pediatric programs was 250 percent of poverty, you can't go below that. But within that, if you were doing Medicaid up to 200 and CHIP up to 250, if you wanted to do Medicaid to 150 and CHIP for the remainder, or bring Medicaid up higher and have more Medicaid than you did before.

In other words, the MOE has several moving parts to it, because it's an MOE that's applied to two programs, right? So the question is whether what we're really interested in is the highest income eligibility or the two programs precisely as they existed. I don't know.

Peter.

COMMISSIONER SZILAGYI: I appreciate everybody's points. I think everybody is making a really good point.

Let me make another pitch for the MOE. So I've never seen a study that shows that a child in Alabama who is 150 percent of the poverty level is that different than a child in Minnesota who is 150 percent of the poverty level. The studies I've seen have suggested that kids, whichever state, who are 150 percent, are higher risk than kids who are 400 percent, in the same state.
So I've been concerned for a long time about this. You know, on the one hand I really want states to have flexibility and innovation, and on the other hand I think it's just concerning to me that state policy or political decisions might affect the health and ultimate outcomes of a child, if you ever happen to be born in one state versus another, as opposed to an adult. So that was one point.

The second point is, to me, the MOE is protection because I wouldn't limit how high states could go. I would limit how low in eligibility states could go, and whether you can blend Medicaid -- or, you know, kind of combine Medicaid and CHIP. That's okay to me, but to me this is sort of a sense of protection which is a large part of what insurance is all about, and it sort of depends -- you know, there's no right or wrong but it depends on where we want to draw the line.

The third point is I find a contradiction between stopping the MOE or letting it expire and the 5 percent concept. If we really believe that adding only 5 percent might induce states to raise the eligibility all the way up to 250 percent -- because, you know, they get only 5
percent more dollars -- then I think states will drop the eligibility criteria once the MOE expires. I mean, I think it's a contradictory, in my mind, to say that only 5 percent extra money is going to sort of convince states to go much higher, but, you know, why doesn't the incentive work, you know, in the other direction?

VICE CHAIR GOLD: Yeah, and I'm going to ask Joanne for help, if she remembers, and maybe if she doesn't she can look over some things.

I thought that we did some talking about the 250 percent at one point. I mean, it didn't -- the 5 percent may have come out of thin air. I thought the 250 percent didn't and it was based on some thought you had, that you had said, Peter --

COMMISSIONER SZILAGYI: No, no. I'm saying it was just a --

VICE CHAIR GOLD: -- that was important. But also that I think our concern was that there still are some states. I remember looking at states and some of them were still below that, and can we get them up. I think it was less that we thought people might come down to it as we were concerned that despite everything that's been done we
still don't have a uniform floor of 250 percent for all kids, and is there any sweetener? That's at least the discussion I'm remembering, which, you know -- so maybe people can fill in and then we can at least answer Stacey's question, and then talk about whether the link between MOE and that is that critical.

COMMISSIONER SZILAGYI: I was just trying to make a point that if a very small incentive will potentially change state policies to increase the eligibility, then a small incentive within a state to try to save a small amount of money might induce them to go down as well. And so bridging that together with my argument about protection, that's why I'm suggesting to maintain the MOE.

CHAIR ROSENBAUM: I also think it's worth remembering that when the original MOE expiration date was set, the assumption was that we be on this 10-year glide path into a world in which the individual market would have 25 million people in it, everything would be functioning, you know, smoothly, and things would have settled into a universal coverage scheme whereby then, if the state wanted to think about somewhat lower Medicaid eligibility levels, or, in fact, you know, CHIP, in theory, might have gone
away entirely. So the 10-year rule has so much noise underneath it, in terms of the picture that was painted in people's heads as they were thinking, 10 years is plenty of time to sort of get ourselves positioned in this new insurance world. And, of course, what's happened is that it's been a bumpier ride than that, and I think, myself -- and I struggle with this question because I'm actually, on these kinds of issues, particularly in states that are states that have sort of, really have taken the bull by the horns and are running a new insurance system, okay -- in those states the time may have arrived to give them the flexibility that we all anticipated, you know, almost 10 years ago, they should have, and unfortunately, at this point, the MOE, it sort of factors over our heads in terms of not just the states where things are sort of -- the throttles are kind of working the way we expected, but we've got some states out there where it's not. And so we have this bifurcated world and, you know, a lot of uncertainty.

And so the theory behind the MOE's expiration after 10 years shifts a little bit, and I think it's worth
just noting that. Penny and then Andy.

COMMISSIONER THOMPSON: So I'll make my other pitch, too, going back. I think you can think of the MOE, Sara, in the way that you described the original hope, which was that you'd have this a period of time, things will settle in, you'd have this robust market, et cetera, et cetera.

Another way that you can think of it is you had your chance, right? And, you know, enough is enough. You have a period of time that you've invested and settling into whatever the world is going to look like, and maybe it's perpetual instability, or maybe it settles out someplace different than you thought it was going to settle out. But you would still at that point cede decisionmaking to the state.

And one of the things that we've said is the strength of the CHIP program, among the many strengths of the CHIP program, is the state endorsement of it, their excitement to have CHIP programs and to run them and to see them succeed. And so I'm just very concerned about an approach that continues to mandate that they stay locked
into that one period in time where they were sitting there
at that given moment that a federal law passed and said
that's where you have to stick regardless. And I do think
that at some point the program has to make its own argument
that it does produce results, it is something that people
value, it is something that contributes to the overall
state of health for the nation and for individual states.

I want to also then just pick up on maybe
something Kit said, which is maybe this is -- I don't know
how many variations we want to go through of different
models. I understand. But Kit made the point maybe we're
being a little too generous about this phase-out of the 23
percent. Maybe it could be a faster or steeper glide path
down to existing match. And, you know, maybe there is some
potential trade-off there to steepen that decline while
still giving states ample time to plan and adjust to the
difference, and maybe build up the incentive after
expiration of the MOE and put dollars after the MOE has
expired if states achieve or maintain an eligibility level
of 250 percent. And so maybe that would be one way in
which to bookend the two sides.

So, on the one hand, you know, we don't want to
take you from 100 to zero, you know, in two seconds, so
we're going to provide some phase-down.

On the other hand, MOE is going to go away, but
when MOE goes away, we're also going to create more
encouragement for you to maintain or achieve an eligibility
level of 250 percent by adding a bit more match on that end
of the equation.

COMMISSIONER COHEN: All great points. I'm going
to add just a couple more, and you gave me an idea, too.

We've done all of our modeling on what CHIP looks
like as of basically 2009 and recently, and we said CHIP
for the most part, from actuarial value, from other things,
that it looks better than what's available in the exchange.
But the one thing we really rarely talked about is that
CHIP can change a lot, and that's one of its upsides and
one of its downsides. But we have been in a period where
CHIP has looked good because it's been locked in. And I
just want to remind us that, you know, when you say no MOE,
it means that wait lists can start in 2019, and we have
been talking a lot about trying to maintain and promote
children's coverage. Just like the ACA moved things
forward, we want to move things forward in that regard.
So I want to be clear that all of our modeling has been based on what CHIP looks like today and it could look a heck of a lot worse under federal law, existing federal law, if the MOE goes away. It could look very, very different in a bad economy and otherwise. So we just have to really be -- like acknowledge that and be comfortable with it.

You gave me an idea, though. I think the issue around the 250 percent is that there's many states that are nowhere near 250 percent. So if 5 percent is not going to encourage them to go from 170 to 250, it's just not going to happen.

What if, though, we did connect some lesser reduction than 23 percent to an MOE where you are? Because I think the take-up of the 5 percent is going to be relatively low in states that already have relatively high coverage -- not the states that are low and that are probably at most risk of dipping below if there's a change in the MOE.

So my suggestion, could we design something where we say you have a phase-down in your FMAP, but it never goes beyond, say, 20 percent, 18 -- whatever the number is,
and we'd have to do some math -- if you keep your levels steady, if you maintain the MOE?

And the other thing I would say is Kit's point is incredibly important. An MOE is meant to be like a floor but not a calcification, and we have to just make sure that any -- you know, that's really for real drafters and legislation, but that we write it in such a way that we are not limiting the ability of change, just not real reductions in eligibility.

CHAIR ROSENBAUM: So just to try and make sure we've got sort of the variants here, one option is keep the MOE, phase down the money, as we're talking about here. Another is phase down the money but get rid of the MOE, and then there's maybe this middle ground of eliminate the MOE but use an incentive instead where the enhanced federal funding would fall only to a certain point for states that, in fact, stayed at least where they were.

Now, what if a state wanted to climb? If a state wanted to climb, would it get the enhanced match or it would only be --

COMMISSIONER COHEN: I mean, we're trying to [off microphone] 5 percent bump presumably. We are trying to
incentivize higher coverage levels.

COMMISSIONER THOMPSON: You know, just one point to make on this conversation, which is MOE does maintain inequities among states, versus what we had written in the straw man was about trying to encourage everyone to get to that 250.

CHAIR ROSENBAUM: Right, come up.

COMMISSIONER THOMPSON: There might be, you know, a worthwhile conversation about which one of those goals are we really trying to maintain. If we had limited -- which we do have limited money. There isn't unlimited money. If we have limited money and we're trying to invest it, is it more important to encourage states across the country to be at that 250 level or for whatever they looked like in 2010 --

COMMISSIONER COHEN: I would say that creates more disparity, because you get the states that are at, you know, 230 or 225 right now, and 250 really doesn't seem like a very big climb, and they get a nice bump. And states that are struggling with low -- you know, have low levels and extreme budget pressures go down. I would say were spending -- you know, we're not spending our money to
that level. We're spending our money on states that have
already committed more money in the first place. So, I
mean, it's a fair discussion for sure. I don't think
there's an obvious answer, but I think that almost promotes
sort of some more disparity, because, again, the states
that can't -- that don't see 250 in their realistic sights,
they're off the table for that conversation.

COMMISSIONER THOMPSON: Yeah, I'm just pointing
out that in the straw man, the 250 is the standard that
we're trying to achieve versus let's maintain whatever you
had in 2010. And I think we should be clear amongst
ourselves --

CHAIR ROSENBAUM: What are we really aiming for?

COMMISSIONER THOMPSON: If we're trying to put
some money behind something, what is it we're trying to do?

COMMISSIONER SZILAGYI: Do you mean if they're
mutually exclusive? I don't understand -- I didn't follow
your point at all about why --

CHAIR ROSENBAUM: Can we get Kit [off
microphone]?

COMMISSIONER SZILAGYI: Oh, I'm sorry.

COMMISSIONER GORTON: So I guess where I'm stuck
is -- and I don't follow this literature, so you guys educate me. Do we have any evidence that throwing any amount of money at these states is going to get them to push their eligibility levels up? Because, I mean, 23 percent didn't seem to do much, and that would seem to me like, you know, a material --

COMMISSIONER COHEN: It does change the calculation for going down -- I do know that -- because you save less. I mean, you save less by going down.

COMMISSIONER GORTON: Fair enough. But I think we shouldn't fool ourselves that we can design an incentive program, particularly one with a huge price tag that's going to be very unpopular with a lot of people. You know, they're looking for us, if we can, to save money. I don't think necessarily we can do that. But we shouldn't either leave money in the budget or put more in to try and accomplish something if, as an evidence-based organization, we have no evidence to suggest that's going to work.

CHAIR ROSENBAUM: We are living through the test of the century of this. As a resident of a state that seems not to be moved by 100 percent funding for poor people --
COMMISSIONER GORTON: Well, I mean, exactly.

CHAIR ROSENBAUM: So money is, I think -- I mean, I think we're all sort of sensing that the money issue may be less the issue than others. I mean, I think we now have the greatest empirical research we will ever have about the fact that money does -- you know, money is only of limited value in --

COMMISSIONER GORTON: Right. It's a wonderful, natural experiment in terms of how states are going to decide how they operate in a federal construct. And --

CHAIR ROSENBAUM: Which is why the MOE then becomes actually the more -- potentially the more important issue.

VICE CHAIR GOLD: But the states didn't like -- the ones who didn't go for it didn't like the ACA. A lot of states like CHIP. So --

CHAIR ROSENBAUM: It's not money.

COMMISSIONER GORTON: Right.

CHAIR ROSENBAUM: And my lovely home state is also a state that, faced with a tremendous bump in CHIP funding, has not done anything there either. So, you know, it's -- I think it does sort of bring matters into
somewhat, you know, clearer [off microphone] about what --
how the calculus plays out.

COMMISSIONER GORTON: So to your point, if what we said is, okay, money doesn't incentivize states to -- states are where they are because they're where they are, it's where they're going to be. They may decide to go up. We'd like them not to go down. Then maybe there's an argument for some reengineered MOE that gives -- that doesn't calcify us in 2009 but sort of maintains some level of coverage. And then I would argue then what we should do in terms of, you know, helping the nation spend money more efficiently and cost-effectively, is get rid of the 23 percent very quickly.

CHAIR ROSENBAUM: Well, that's why before I raised the issue of the top level. The MOE essentially has two parts to it. There's the top level, you know, what's the highest income level for public insurance coverage for children in your state? But then because the MOE essentially sits on top of two separate programs, there's the sub-level of how you distribute children between the two programs. So one issue is: Do we keep a top level standard? If you were at 200 percent of poverty, you can't
go below 200 percent of poverty. But within that, if a state were to want to shift more toward CHIP and away from Medicaid, that would not be subject to the MOE.

COMMISSIONER GORTON: Well, so the only thing I would say is we should include the third bucket, so CHIP, Medicaid, and the tax credits and subsidies associated with the exchange product.

CHAIR ROSENBAUM: Well, there you've got a problem, though, because that -- because of MEC, because there's no -- it's not a three stacker. You've got MEC over -- you've got premium subsidies over here and you've got Medicaid and CHIP acting as minimum essential Congress over there. In other words, from a state's perspective, if you wanted to be draconian about it, which one state already has tried to do, you would just eliminate anything above 133 percent of poverty and say children go into the exchange. So the whole issue with the MOE is to not have that kind of option --

COMMISSIONER GORTON: Right, but to have all the children go into the exchange as it is currently constructed, which Peter appropriately -- I wouldn't have characterized it quite the way he did, because the
actuarial values in the exchange are --

CHAIR ROSENBAUM: You mean if your exchange market looked different.

COMMISSIONER GORTON: So we create a children's product, and we say, okay, if you have --

VICE CHAIR GOLD: We don't have that authority [off microphone].

CHAIR ROSENBAUM: No, no.

COMMISSIONER GORTON: Congress does.

CHAIR ROSENBAUM: Were Congress to follow our recommendation on the innovation, and the exchange products were essentially upgraded, then what you're saying is do we really need the MOE.

COMMISSIONER GORTON: Well, I'm saying that states that enroll those people get credit for those because they're in a qualified minimum benefit plan.

CHAIR ROSENBAUM: Yeah, yeah. I'm sorry. Toby had his hand up.

COMMISSIONER DOUGLAS: I've been staying quiet, but overall, you know, what I like about the straw proposal is -- there's a lot about flexibility besides continuation, which I strongly agree with -- is flexibility. When we
start then taking away and saying no, we're going to keep
the MOE, we're going against what CHIP started with, a lot
of state-driven autonomy and approach. You know, I just
think we're sending the wrong message. We want innovation.
You want to think about doing exchange -- you know, other
ways, but you can't know what's right in your state
approach, and we're going to still create this federal
overlay on that. And so I strongly don't agree with that.

CHAIR ROSENBAUM: That is certainly where I saw
the tension, and I completely reverberate to what Kit is
saying, although there's so many dependent, you know,
moving pieces, who knows where it would end up. But if
we're saying to states we'd really like to encourage you to
try something different with your insurance markets, and at
the same time that we're saying that, we're saying to them
but you really can't do anything different with your CHIP
and Medicaid markets -- although I suppose you could say
that it's still CHIP if they're rolled into the exchange,
you know, that's an interesting question. At some point I
find that we're a little confused, that's all.

But at the same time, I mean, I feel very
strongly that the MOE assumed a glide path that we've never
achieved, and so, you know, there's real cause for concern.

Well, we've certainly given ourselves a lot to chew over here in terms of the next steps, which is just to remind everybody, the staff are going to bring us an attempt at a refined outline in October which will really be, I think, the time for any last discussion because that package then will come back to us for a recorded vote in December.

VICE CHAIR GOLD: Just I hope we can go back to what we said at the beginning. For many sessions we've seen a lot of data. We've seen that -- you know, the whole idea originally was CHIP would be able to be folded into the exchanges. We looked at data and saw that we can't do that. We looked at the political environment and saw that that part wasn't getting any traction to have it done.

So I think our logic of going for, you know, reasonably lengthy extension of CHIP while providing some flexibility for those states that are able to come up with some creative solutions that maintain the CHIP requirements, pending figuring out this national role or something, makes sense.

So I just don't want us to get too off track or
too complicated with this thing. I mean, I kind of like
the straw man thing, and I understand the debate on
maintenance of effort. I still have to think that over one
way or another. But I thought the straw man worked, and I
thought that I was hearing most people think that, in
general, it did. I'm just concerned that, you know, in the
interests of trying to deal with all sorts of good
intentions we have, that we not make things too
complicated.

CHAIR ROSENBAUM: Well, you know, who ever said
child health policy was easy? I mean, we deserve to be
every bit as complicated as everybody else when we're
dealing with children.

So we do have time for public comment, and I
invite those who would like to comment to come up.

Thank you. Thank you so much, Joanne. That was
great.

### PUBLIC COMMENT

* MR. REUSCH: I am Colin Reusch with the
Children's Dental Health Project. I appreciate all the
work that staff put into this and all the discussion, but
straw men are set up to be knocked down. I'm happy to take
a couple of blows. It does, especially with regard to the subsidy option, seem a little overly complicated and potentially fraught, especially for oral health services for children, given the current state of dental offerings in the marketplace and how rules in the marketplace do and do not apply to them, specifically with regard to cost-sharing subsidies, which do not apply to certain dental offerings to children.

In general, with regard to the five-year timeline, I would encourage the Commission to think realistically about how quickly the marketplaces are proceeding towards an ideal situation with children and remind them that they are not exactly proceeding with alacrity.

And with regard to the MOE or some other form of floor to maintain eligibility levels, I would ask the Commission to consider the fact that states often do, when given the flexibility, make decisions that perhaps are in opposition to programs that do stand alone to make an argument for themselves, so thank you.

CHAIR ROSENBAUM: Thank you.
MS. LOVEJOY: Hi. I'm Shannon Lovejoy with the Children's Hospital Association. Thank you for the opportunity to provide comments. We've been encouraged by the discussion of providing a longer-term extension of CHIP and do want to remind you that we are hoping that in any process of any consideration of CHIP that we are hoping to not take kids backwards, and the MOE has been a critical part of maintaining high levels of coverage among children.

But I did want to touch on something with the quality and some of the discussion around quality. The Pediatric Quality Program was the first significant federal investment in quality. A lot of quality measurement development has been driven by the Medicare program, and for obvious reasons, they have not focused on pediatrics.

And state reporting is a very big and important component of that, but that's not the only piece of quality. And quality funding needs to really encompass the life cycle of quality measurement, which includes the development of new measures, but it also includes the endorsement of these measures because that is a very costly process that needs to happen. It also includes the stewardship of these measures.
So it really shouldn't be thought of in any terms of one specific component but really should look at the lifetime, and we'll follow up in more detail on that aspect. Thank you very much.

MS. WHITENER: Hi. I'm Kelly Whitener with the Georgetown Center for Children and Families, and thank you all for the discussion today. I would like to reiterate what some of the other commenters have already said that we definitely support your discussion and consideration of a longer-term CHIP extension. Five years-plus sounds great to us.

On the MOE, I would like to just sort of go back a little bit and think about exactly what it does cover. There was a lot of discussion about eligibility levels, and, of course, that's critical. But the language also has provisions around the standards, methodologies, and procedures that the states had in place. And that may be some of what you're worried about and would like to have the flexibility to change, but to put a finer point on what that means, that's premiums. It's waiting periods, lockout periods, waitlists, freezing programs, and capping programs. So, to the point Andy made earlier, you could
see CHIP look very different without the MOE,
notwithstanding maintaining some higher level of coverage.
You could really see a lot of kids lose coverage because of
some of those other things.

Certainly, Arizona is the best example of what
happens without an MOE, and it wasn't pretty. Their
coverage levels for kids in the CHIP income range were the
lowest in the country, and we're very happy to see that as
of the 1st of this month, they have reopened CHIP.

That was very much linked to the bump, so
definitely appreciate that your conversation around the MOE
is thinking also about how it's connected to the federal
funding for the program.

But Arizona is not alone. Other states are
looking ahead at pretty dismal financial picture and
thinking about what they might do when the MOE goes away.
The most public example of that is in Oklahoma as part of
their budget rebalancing act to move all CHIP kids to the
marketplace.

So, despite a popularity in the program and a
real interest in covering kids, when states are looking at
their budgets and see that the marketplace is free to them
and that publicly it wasn't look like a loss of coverage,
it certainly wouldn't be covered that way other than by
people like us, but not on the nightly news. You would
really see a decline. I would just encourage you to think
about that.

I think also to think back about your own
principle on not going backwards and the work that you've
done to show that there's a real difference between CHIP
coverage and marketplace coverage, without the MOE, I think
you would be going backwards, so you would have to be
willing to overcome that principle or push that principle
aside in favor of some of the other principles you're
trying to balance in terms of state flexibility and others.

So my final point on the MOE is really that if
you think about the likelihood of some of the marketplace
changes that you have also discussed as really needing to
be foundational prior to any end of CHIP, such as fixing
family glitch, I don't think that's happening in the near
future. I think it's probably a very long way off for
political considerations and also because it's very
expensive to fix that and some of the other affordability
problems you've identified in the marketplace. So it's
just really unrealistic to expect that that's going to happen quickly, so it kind of supports some of what Penny had to say about being realistic on your timeline that may be going a little bit longer.

And then, finally, you had some conversation about increasing eligibility levels in Medicaid or CHIP, and I would just encourage you to make sure that you provide for that statutory flexibility in your recommendations. Thank you.

MR. CROSS-CALL: Hi. Jesse Cross-Call, the Center on Budget and Policy Priorities, and I want to echo a lot of the comments that were just made about the MOE. We believe that the MOE has been a big reason that kids' coverage has continued to expand during this decade, and we're really worried about incentives for state if you take away the MOE. The examples from Arizona and Oklahoma, I think really speak to that, that states are already eying what happens in 2019 as a way to roll back eligibility levels.

And then if the MOE goes away, it's not just a question of whether those kids move into the exchange. The fact is it's very likely many of them would become
uninsured, so just urge you to reconsider where you are on
the MOE right now. Thank you.

MS. FITZGERALD: Hi. Carrie Fitzgerald from
First Focus. I would also like to reiterate how happy we
were to hear you talk about five years and the longer
extension. We think that's very good for states, for
families, for providers, for planning. It's very, very
helpful for them.

As far as the MOE, this conversation was pretty
concerting and a little worrisome. I'd like to go back and
talk to some of my colleagues, and we'd like to send you
written comments on that issue. Thanks.

CHAIR ROSENBAUM: Thank you.

Well, seeing no more comments, we are adjourned
for the day.

* [Whereupon, at 4:36 p.m., the meeting was
adjourned.]