PUBLIC MEETING

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

Thursday, January 28, 2016
10:39 a.m.

COMMISSIONERS PRESENT:

SARA ROSENBAUM, JD, Chair
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PENNY THOMPSON, MPA
ALAN WEIL, JD, MPP

ANNE L. SCHWARTZ, PhD, Executive Director

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1 P R O C E E D I N G S

2 [10:39 a.m.]

3 CHAIR ROSENBAUM: Why don't we take our seats?

4 Well, welcome, everybody to the winter wonderland

5 that is Washington, D.C., with some snow. Happy 2016, and

6 this is our first MACPAC meeting of the year.

7 Just to draw your attention to the agenda, we

8 have added a session at the end of the day, a presentation

9 on Medicaid and prescription drugs, which was not

10 previously on the agenda. So that will now take place at

11 4:30, with a 5 o'clock public comment session, followed by

12 adjournment.

13 We have a very busy day, lots of material to

14 cover, and we're going to plunge right in with Chris

15 Peterson, who is going to pick up where we left off at our

16 last meeting, an ongoing discussion about children and our

17 work on children's issues. We will be covering a range of

18 issues today, beginning with children and the future of

19 children's coverage, affordability issues around children

20 and employer-sponsored coverage. And then in the afternoon

21 we will move to long-term services and supports, and

22 specifically the issue of functional assessments, and also

1 the issue of providers serving Medicaid patients, some new
2 data and information that we haven't seen previously, a
3 historical review of proposals, many, many proposals over
4 the decades to reform Medicaid, various alternative
5 approaches to addressing the growth in federal Medicaid
6 financing, followed, of course, by the added prescription
7 drug session.
8 So why don't we plunge in with Chris to start us
9 off? And I want to add a special welcome to our new
10 Commissioners. We had, of course, retirement of several of
11 our Commissioners at the end of 2015. We have wonderful
12 new Commissioners who are now here. One actually has a
13 formal role to play today, and everybody else is filled
14 with knowledge and observations and things to say. So
15 welcome to you all.
16 Take it away, Chris.
17 **### Review of Draft Chapter for March Report: Design**
18 **Considerations for the Future of Children's**
19 **Coverage: Focus on Affordability**
20 * MR. PETERSON: All right. Thank you, Sara.
21 Since the two-year extension of CHIP enacted last
22 year, the Commissioners have returned to broader questions

1 on the future of coverage for low- and moderate-income
2 children, going beyond simply those children now enrolled
3 in CHIP. In the past several meetings, we've provided a
4 variety of analyses to help you think through the larger
5 issues around where children get their coverage, how much
6 it costs, whether it's affordable, and a number of other
7 considerations.
8 In the third session today, we will briefly
9 summarize some of that research, but in this session, we
10 want to give you a final opportunity to reflect on the
11 findings in the draft March chapter that you have in your
12 materials, which in particular focuses on the affordability
13 of children's coverage, comparing separate CHIP to
14 subsidized exchange coverage.
15 This chapter is based on results we've already
16 presented at the October and December meetings, so I'm not
17 going to spend the time to walk through the details of
18 those findings and methods once again, and that way we can
19 leave time for your discussion.
20 But particularly for new Commissioners, if any of
21 the specific content of the chapter was not clear or you
22 want to ask questions about that, feel free to do that

1 here, or we can even chat about it at the break.

2 Today we have three presentations on issues

3 affecting children's coverage, and we will stop after each

4 presentation to give ample time for your discussion. As

5 you see, we'll begin with this session reviewing the draft

6 chapter. Then we'll talk about new findings that we have

7 on the affordability of children in separate CHIP and

8 comparing that to employer-sponsored coverage. And then,

9 finally, we'll have a session on the Commission's past work

10 on children's coverage, both the evidence that we've

11 accumulated as well as past Commission recommendations, and

12 then talk about next steps.

13 So for this presentation, which follows the

14 structure of the chapter, I'll provide some context and

15 then briefly go over the key findings from the chapter and

16 then turn it to you for your discussion and comments on the

17 chapter itself.

18 For context, of course, since CHIP's enactment,

19 children's uninsurance has fallen from 9.9 million in 1997

20 to 3.3 million in 2015, and that's, of course, not only

21 from increased CHIP enrollment but Medicaid enrollment as

22 well. And when you look at total enrollment of children in

1 Medicaid and CHIP, it totals 44 million children -- 36
2 million in Medicaid-funded coverage versus 8 million in
3 CHIP-funded coverage. And as you know, states will begin
4 running out of their federal CHIP funds in October 2017,
5 and a key question is about the future of CHIP given the
6 availability of subsidized exchange coverage, and other
7 sources of coverage as well.
8 So we know, of course, that there's variation in
9 affordability by state in separate CHIP as well as in
10 exchange coverage. On the CHIP front, cost sharing as well
11 as benefits and eligibility vary by state, but they do have
12 to meet federal standards, and with respect to the chapter
13 in particular, those standards are that premiums and cost
14 sharing are limited to 5 percent of family income.
15 Then on the exchange side, eligibility, benefits,
16 and cost sharing are set in federal statute under some
17 broad parameters, but there's still variation that exists
18 by state and within state among plans in terms of the cost
19 sharing and the benefits. Now, some of that may be
20 mitigated somewhat, that variation, based on the new rule
21 that came out, proposed rule that came out last month that
22 was proposing to have some standardized cost-sharing levels

1 that plans could use in exchange coverage.

2 So the purpose of the chapter and the analysis,
3 which we've presented previously, was to provide more
4 nuanced insights on the affordability of coverage comparing
5 separate CHIP to exchange coverage. The prior research,
6 including our own, had found that on average children would
7 face greater cost sharing in exchange plans relative to
8 separate CHIP. But based on the Commission's request for
9 more details, we have provided more analysis in this draft
10 chapter to look at how exchange plans and separate CHIP
11 differ by both premiums and cost sharing and by state and
12 across the four key income categories that apply for
13 subsidized exchange coverage, and then comparing that to
14 CHIP in those income ranges.

15 And then the Commission's other interest was,
16 well, yes, we suspect and now know that exchange coverage
17 costs more on average than separate CHIP, but what share of
18 children would actually face a lot more if they were moved
19 from separate CHIP into exchange coverage and what are the
20 characteristics of those children. So that was the purpose
21 of the analysis.

22 And the key findings, without getting into all

1 the numbers that you have in the draft chapter and that
2 we've previously presented, are that out-of-pocket spending
3 for premiums and cost sharing in exchange coverage is
4 higher than CHIP in the 36 states with separate CHIP that
5 we looked at.
6 Second, out-of-pocket spending in exchange plans
7 increases substantially as income rises, and that's
8 consistent with the cost-sharing reductions in exchange
9 coverage.
10 A third point that the Commission wanted to be
11 made clear is that differences in states' CHIP income
12 eligibility means that the group of children receiving CHIP
13 cost-sharing protection varies by state. In other words,
14 one state, at 200 percent of poverty, children will qualify
15 for CHIP, and they'll get that cost-sharing protection. In
16 another state CHIP doesn't go up that high, so, therefore,
17 exchange is the fallback for publicly subsidized coverage.
18 And then, finally, children facing the highest
19 spending in exchange coverage do not all have predictable
20 chronic health care needs and, in fact, some of the
21 children who would face the highest out-of-pocket spending
22 in exchange coverage, they don't have chronic health care

1 needs, what happens is they have an unexpected health care
2 event during the year. So it's a mix of children.
3 So the chapter ends by raising several policy
4 questions regarding low- and moderate-income children that
5 the chapter does not try to answer, and these questions
6 are: Are current levels of premiums and cost sharing in
7 subsidized exchange coverage appropriate? How much
8 variation in premiums and cost sharing should exist across
9 states, whether we're talking about CHIP or exchange
10 coverage? And, finally, how could the information on the
11 characteristics of children with high health care spending
12 be used in designing a policy to ensure that coverage is
13 affordable?
14 And, finally, we wanted to make the point that
15 affordability for families is only one of many potentially
16 competing policy goals. So affordability is not the only
17 issue as the Commission moves forward, of course, but that
18 just happens to be the focus of this particular chapter.
19 So today we're not expecting you to try to answer
20 all these questions. Feel free to weigh in. But, really,
21 our primary purpose is to make sure that the tone and the
22 content of the chapter is right.

1 And one final note is that the version of the
2 chapter that you have does reflect the comments from
3 external reviewers.
4 Thank you.
5 CHAIR ROSENBAUM: Thank you very much, Chris.
6 So we've asked two of our Commissioners to offer
7 some formal responses before we open it up for general
8 Commissioner response and reaction. So, Peter, why don't
9 you -- oh, Sharon's going to start off? Terrific. And then
10 we'll move to Peter.
11 COMMISSIONER CARTE: Thank you, Sara. I think as
12 probably the less analytically skilled, it will be more
13 appropriate for me to go first. Then everybody --
14 [Inaudible comment off microphone.]
15 COMMISSIONER CARTE: Chris, when I look at --
16 this is great data, and I think this is another cut that,
17 you know, gives us a more refined look at the income
18 breakouts for different ranges for families and CHIP and in
19 exchanges. But I still really struggle with, I guess, when
20 you look at the modeling, like moving from looking at
21 single child coverage to the family. Could you just take a
22 few minutes to walk us through the premium assumptions that

1 you talk about in Appendix 5.B about how those comparisons
2 are made? Because, you know, as -- and I think I probably
3 went to do that the last time you presented data, so it's
4 not that we can just like multiply the costs for children
5 per the income limits by looking at, say, two children,
6 whether they exceed a 5-percent income range, or four
7 children. You've done modeling to try to compensate for
8 the parents' presence in exchange plans versus children,
9 even though we have just approximations there. Could you
10 just explain that a little bit?
11 MR. PETERSON: Sure. So a couple things.
12 First of all, our approach at this stage is to
13 take a narrow look at what children in these families would
14 pay out-of-pocket for their cost sharing and premiums.
15 What you're suggesting is, you know, well, wouldn't you
16 want to look at the entire family, what the entire family
17 is paying when they're enrolled in exchange coverage? And,
18 yes, that is something that is of interest. But our
19 purpose was to set up the analysis to look at what the
20 Commission was interested in in terms of who are the kids,
21 in particular, who would face the biggest cost sharing and
22 what are their characteristics.

1 So that was why that particular path was chosen,
2 and certainly, you know, we can try to look in the future
3 at a more kind of comprehensive look at affordability for
4 all family members. But at this stage, that was why we
5 went down that path.
6 Then, second, on the premium assumptions, let me
7 just try to walk through this because it's rather
8 complicated.
9 In exchange coverage, what happens is you are
10 required on the premium side to pay a certain amount out-
11 of-pocket for the premiums. And so what can often happen
12 is if the parents are enrolled and qualify for exchange
13 subsidies, then adding a child then means that they are
14 going to -- the family is not going to face any marginal
15 costs for adding the child.
16 So, on the one hand, you could say, well, wait a
17 minute, if the parents are already enrolled, then the
18 child's free, so shouldn't we say that there are no
19 premiums? So that's one way to look at it.
20 The other way to look at it is to say, well,
21 we're talking about kids who are losing coverage and maybe,
22 in fact, the parents aren't enrolled, but they're willing

1 to enroll their children. And if that's the case, then
2 they would have to pay the entire amount out-of-pocket
3 potentially before the family even hits that threshold
4 where the premium subsidies kick in.
5 So what we have is this dilemma of two sides of
6 this equation, and what the actuaries who worked on this
7 had suggested and had done previously was to say, look,
8 what makes the most sense is to assume that the whole
9 family is enrolled, number one; and we have known from our
10 other modeling that generally the only way a child is going
11 to get enrolled is if the parents are enrolled. So that
12 seems like a safe assumption.
13 So then the second question is: How do we
14 apportion to the child the premium? And so the approach
15 was to say calculate what the premium is out-of-pocket for
16 the entire family, and what share of that is attributed to
17 the child is based on what share of the total premium is
18 attributable to the child. So that was the assumption
19 used.
20 COMMISSIONER CARTE: So we're really trying to
21 take the whole family premium and make some assumptions to
22 place it on a per child basis in order to compare it to

1 CHIP. And we assume that the QHPs in the exchange include
2 the parents with that additional cost, but we don't have
3 similar assumptions about the CHIP kids -- the CHIP
4 families, whether or not those parents have coverage at
5 all, or --
6 MR. PETERSON: Well, we're assuming that they're
7 going to enroll in exchange coverage. What we don't know
8 is how much are they spending out-of-pocket on their health
9 care? How much would they face in cost sharing? Are they
10 kind of a high-cost, high-need adult and adding that to the
11 picture? So we didn't attempt to do that.
12 COMMISSIONER CARTE: And we don't know if the
13 CHIP parents could be in employee-only coverage or -- I
14 mean, it just seems like there's so many permutations. I
15 just find it hard to believe that the model really captures
16 comparability between -- I mean, and I'm interested to hear
17 anybody else's thoughts on that. But I guess what
18 surprised me when I went through all the tables in the
19 appendices is that it did seem that the exchange plans
20 compared favorably in that you didn't see lots of
21 households paying more than 5 percent of their household
22 incomes. It was smaller amounts, smaller percentages. It

1 might be good if I gave an example here.

2 On 5.A.6, when you look at the share of children
3 with out-of-pocket spending above 5 percent and with
4 between 150 to 200 percent, which is where most of the CHIP
5 families would be, you see an average -- not an average,
6 but it looks like the range is anywhere from around 2 to 7
7 or 8 percent.

8 MR. PETERSON: Right. And what's a great point
9 about that is CHIP prohibits cost sharing and premiums at 5
10 percent of income. So, on the one hand, what that says is
11 all of these states, in all of these states there are some
12 children who are going to face a level that is prohibited
13 CHIP under current law. But, on the other hand, you could
14 say but it's not really a lot of children, so is that okay?

15 COMMISSIONER CARTE: Right. But, on the other
16 hand, when you look at the range -- I guess what I'm
17 questioning is whether or not this data portrays the
18 economic burden that these low-income families have to have
19 when you look at the range of difference between having a
20 CHIP -- the cost sharing and premiums on a CHIP plan
21 between 133 to 150, going from $31, an annualized amount,
22 up to $511, or when you look at a family between 151 to

1 200, and it goes from $113 up to $915. I think that's what
2 I'm trying to convey, no matter how awkwardly.
3 Another question I have, or comment, is that, you
4 know, I've heard some of the major insurers for the
5 exchange plans say that they are struggling and losing
6 money because so many families in the exchange are
7 disenrolling throughout the enrollment period -- I mean the
8 coverage year. Is there any data available or would we be
9 able to access any data about those disenrollment rates?
10 MR. PETERSON: On the exchange side, I've seen
11 very little on the disenrollment.
12 CHAIR ROSENBAUM: I don't think we have yet that
13 level of information. I certainly have not seen it.
14 COMMISSIONER CARTE: Would there be the
15 feasibility of the Commission reaching out to HHS --
16 CHAIR ROSENBAUM: We certainly can ask.
17 COMMISSIONER CARTE: -- or to NAIC to say, you
18 know, could we look at that data?
19 CHAIR ROSENBAUM: The issue is the stability of
20 the exchange coverage because of the affordability
21 question.
22 COMMISSIONER CARTE: Right.

1 MR. PETERSON: The only other thing I'll say is
2 that there's a report that just came out this month. It
3 was from Washington State, and it was their exchange. And,
4 so, they looked at the level of churning between exchange
5 coverage to Medicaid. It was more focused on the adults,
6 but I think we'd have to look at a state-based exchange in
7 order to get good data about kind of the movement between
8 exchange coverage and Medicaid, and particularly to get
9 CHIP in that mix would be another thing, as well.
10 CHAIR ROSENBAUM: Sharon, I think a number of
11 these things, we may not be able to fully answer the
12 questions that you're raising, but I think we can probably
13 do a better job in clarifying what these data do and don't
14 tell you and say, you know, these are other things that --
15 in terms of where the Commission takes this information and
16 how it feeds into the decision making process, some of
17 these other factors.
18 COMMISSIONER CARTE: Right.
19 CHAIR ROSENBAUM: We can certainly clarify that,
20 and to the extent that we can find data on some of these
21 things, some of which are more anecdotal at this point, we
22 can dig around to the extent we have those. As you move

1 forward down the sort of what is the true measure of
2 affordability, we can certainly make sure that that's
3 available.
4 COMMISSIONER CARTE: Right. I just think that
5 that would be -- I realize when I ask that the data may not
6 be existing or may not paint a complete picture, but going
7 back to the Kaiser Foundation survey that they did of
8 people talking about affordability as being key to their
9 enrollment and ability to access insurance, I just think
10 the more information we can bring to that over the coming
11 year, the better.
12 COMMISSIONER ROSENBAUM: Well, I do think the
13 point you're raising, the first point, which is being very
14 clear about the, essentially, the archetypal comparison
15 we're making here, we are talking about -- because there
16 are so many things we don't know because the in-depth data
17 about insurance coverage by source of coverage is still
18 relatively limited. So, for example, is the archetype
19 families who are on -- where the parents are on -- they're
20 enrolled in a qualified health plan, but they're buying
21 CHIP for their children, and then were CHIP to go away,
22 they would have to add the child to the plan, or are we

1 talking about the archetypal family, your hypothetical of
2 the parents who have coverage for themselves through their
3 employer. The employer doesn't even offer dependent
4 coverage. So, they are not excluded by the family glitch.
5 Right now, they're buying CHIP coverage, but what if they
6 had to go buy a child-only plan?
7 So, just knowing what the comparisons are that
8 we're making and why we decided to go with sort of one
9 model of family or another model of family, I think, might
10 help just show Congress the questions we're answering.
11 That's all.
12 Peter.
13 COMMISSIONER SZILAGYI: So, first of all, I
14 think, as always, Chris, I think the chapter is really
15 excellent. It's very clear. It's factual and very
16 responsive to our prior comments from all the Commission
17 members before.
18 I also think the tables are really understandable
19 and you did a really good job -- you know, we just had an
20 in-depth discussion about what are different options for
21 families or different situations, but my understanding is
22 that the model tries to take the -- you know, tries to

1 assume those different permutations and gives -- and
2 creates an average result, and that's what's shown in these
3 tables. And there are assumptions to those models, but I
4 think we have to balance being able to show tables and
5 results that are really clear with drowning people in the
6 facts, and I think you've really gotten a really nice
7 balance with showing the average, even though there's
8 obviously assumptions to the model.
9 I also think that this chapter highlights the
10 unbelievable variability in what children and families face
11 across states, and that's something that we as a Commission
12 is going to really face about sort of the -- what is
13 acceptable, because as I've said before, I don't quite
14 understand why a poor child should have such variability
15 depending on which state the child lives in. So, that's
16 sort of a bigger topic.
17 So, I just had a couple mild -- minor
18 suggestions. In the background, I would suggest that we
19 could emphasize a bit more of the context. So, why is cost
20 sharing important, you know, and this is particularly if
21 people would read this chapter and haven't read prior
22 chapters. So, maybe a very brief summary of the literature

1 with references about the impact of changes in premium or
2 changes in cost sharing and the total cost, particularly as
3 it relates to low-income families, again, without being too
4 extensive, because cost sharing is important, and you
5 remember we've shown before in prior chapters about the
6 level of discretionary spending that low-income families
7 really have, the very low level of discretionary money
8 available after low-income families have used up their
9 income on housing and all of the other costs of living.
10 So, one point was why is cost sharing important,
11 and maybe a little bit more on why we are looking at
12 separating premiums and other out-of-pocket costs, and I
13 think that is important, particularly as the literature
14 suggests, the premium costs might affect enrolling in a
15 program. So, this is the affordability question.
16 And, you made a good point in the chapter that
17 the majority of the additional costs in the exchanges were
18 due to premiums, so --
19 The second is maybe a little bit more explanation
20 about why we selected the second lowest cost silver plan as
21 the comparison, and I think that is a good comparison, but,
22 you know, maybe a little bit of an explanation about why,

1 and if there were other comparisons, how that would affect
2 the results.
3 And, third, although it's obvious to many people,
4 why are we using two percent, five percent, and ten
5 percent. So, maybe a little bit more explanation for
6 people who would read this chapter about why those
7 particular numbers were chosen here, and I think they make
8 total sense, but -- and they're grounded partly in the CHIP
9 experience and what the federal law allows under CHIP and
10 also in the literature, that two percent, or more than two
11 percent for low-income families, an additional two percent
12 expense is actually a pretty serious expense.
13 And then I only have one other point in terms of
14 the tables and everything, and I thought they -- I thought
15 that they were laid out really, really well. It may be
16 possible to, in Table 5.3 and 5.5, to somewhere -- or maybe
17 in the text -- to highlight the millions of children -- the
18 numbers of children in the different federal poverty levels
19 that would be potentially affected. So, right now, we show
20 percents, but what are the numbers. And, I think that is
21 possible at the national level. So, instead of just
22 saying, maybe, you know, like, how many children are -- we

1 clearly have that -- how many children are there between
2 150 and 200 percent of the poverty level.
3 So, obviously, cost sharing is going to be
4 greater for the 200 to 400 percent of the poverty level,
5 but the vast majority of kids in CHIP are not there.
6 They're actually below 200 percent of the poverty level.
7 So, how many children does that affect? So, just a very
8 minor point, but I think that might clarify some of the
9 results.
10 But, overall, I thought this was a really
11 outstanding and very clear chapter and it sets the stage
12 for the future chapters that we'll do.
13 MR. PETERSON: Thank you. The only thing I'll
14 comment on in that last piece is there is kind of, I think,
15 a passing reference that the latest data that we had was
16 nearly 90 percent of kids currently in separate CHIP are
17 below 200 percent of poverty. The hope is that, you know,
18 the latest information from the CHIP administrative records
19 would have later information, more accurate information,
20 but at this point, it's still problematic. So, I think
21 that little ditty may be all we can do. So, just a heads
22 up. If you don't see us make a change in response to that

1 comment, you know, it's we want to do that and we hear you.
2 CHAIR ROSENBAUM: Great. Why don't I open it up
3 for general discussion now? Thank you, Sharon and Peter.
4 Alan.
5 COMMISSIONER WEIL: I'm trying to be shy and
6 retiring and not succeeding. This is terrific, and as a
7 new member, of course, I haven't been through the earlier
8 conversations, but I want to follow up. I had a similar
9 frame but different focus than Peter's, which is that the
10 top line notion that coverage that's not as comprehensive
11 is going to lead to a larger share of families having a
12 larger share of their income is sort of an arithmetic
13 issue. It's when you go below that that it really gets
14 interesting. And the area for me -- Peter pointed out the
15 state by state variability. The area for me that stood out
16 as new and potentially a second order way of thinking about
17 it is the health status and health conditions associated
18 with those who exceed the various income thresholds.
19 And I was trying to think, and I'm just going to
20 tee it up because I think it -- because I hope that with
21 more information, we can think more about it and
22 policymakers can think more about it. But, for example,

1 the high prevalence of mental health conditions, well, my
2 assumption would be that if you have children with poor
3 coverage for mental health conditions and they have mental
4 health needs, there will be a lot of unmet need. The
5 inpatient acute events will be kids who end up in the
6 hospital, and they have a lot of uncompensated care, but
7 they probably do get the urgent care they need when they
8 are admitted and then the family has a financial burden
9 over time. You know, the high prevalence of asthma is both
10 the prevalence of asthma, but also poor management of care,
11 because, presumably, that's partly associated with a
12 hospitalization that might have been avoidable.
13 So, I would just say the more you can pull this
14 out and highlight it, it's not just interesting, and it's
15 not just descriptive of who's affected, but it also has
16 some really interesting implications for the longer-term
17 policy discussion about what is coverage for kids and what
18 does exchange coverage look like, and then the additional
19 information about employer coverage, to sort of get at this
20 question of how does benefit design affect different kids
21 differently, not just in actuarial value, not just in
22 percent of family income they have to pay, but actually

1 having different health effects or different access
2 effects. So, the more we know about this, I think it would
3 be really interesting.
4 And, just very specific, and I think this may be
5 a little along the lines of where Peter was going in terms
6 of number. So, I look at Figure 5.1, just to pick one of
7 them, and you've disaggregated the share of children for
8 chronic, non-chronic, acute by different spending levels.
9 They all add up to 100 percent. But the numbers of kids in
10 each of those three rows is very different. Figure, not
11 table. Sorry. Figure 5.1. So, just again to sort of
12 capture the size of the issue, not just the distribution.
13 Anyway, I think this is really great stuff.
14 CHAIR ROSENBAUM: Let me just add one other
15 point. I thought it was -- I thought you did a wonderful
16 job with this, and again, it's contextual. It sort of
17 follows up on Alan's point. I think for purposes of -- not
18 so much for purposes of this chapter per se, but for
19 purposes of leading into some of our other work, it is
20 always valuable to point out to people that we are focused
21 on children between 100 and 150, and 150 and 200, because
22 that is children's target.

1 At the 200 percent of poverty level, the CHIP
2 protections fall off very rapidly, and the double-whammy,
3 of course, is that so do the cost sharing reductions. And,
4 so, you not only have this issue -- the immediate issue of
5 what if suddenly the exchange model were substituted for
6 the CHIP model, but you also have a situation that I think
7 is relevant to any discussion we have, which is that given
8 how states have targeted their funding in CHIP, and given
9 the underlying rules of the exchange, children who are
10 still living at quite low incomes suddenly find themselves
11 in situations where the actuarial value of their plan is
12 going to drop to 73 percent and there's no CHIP. I live in
13 Virginia and, of course, this is a big issue in Virginia.
14 And, so, it may help in here just to tweak
15 everybody's reminder at the beginning of what we are
16 focusing on and why, going to also the point Peter raised,
17 and reminding everybody that here, we're talking about the
18 loss of protection for a group, but there's also the
19 question of the children who are immediately adjacent to
20 the protections we're looking at.
21 COMMISSIONER SZILAGYI: Two other very quick
22 points. Oh, sorry. One is that if we were looking for

1 more work, it may -- and I'm just maybe too new to the
2 Commission to know whether we've done this -- it may be
3 worthwhile thinking about a chapter on what is the evidence
4 about cost sharing for children of different economic
5 levels and what is known about the impact for affordability
6 or utilization, use of what kind of services, and
7 potentially health outcomes. As always with children, a
8 lot isn't known, but there is a good literature.
9 And, my second point was I thought this chapter
10 made a great point that was a little surprising -- maybe
11 surprising to me, but it shouldn't have been -- in that you
12 cannot predict with high certainty which children will face
13 -- will be in families that face significant levels of cost
14 sharing. And that's partly because of the up and down
15 nature of some chronic diseases in children as they evolve,
16 or they may grow out of certain chronic diseases, and
17 partly because accidents and trauma and all sorts of other
18 things happen to children.
19 So, as we think about design of health insurance
20 programs for low-income children, this chapter sort of
21 nailed to me that it wouldn't be possible to predict super
22 accurately a subgroup of children who maybe should be

1 treated differently than other children. So, that was very
2 well highlighted, I thought, by the simple facts.
3 MR. PETERSON: The only thing that I'll add is we
4 have online as a web product a literature review of the
5 effect of cost sharing premiums on children. Now --
6 COMMISSIONER SZILAGYI: [Off microphone.] Oh, I
7 missed it.
8 MR. PETERSON: So, what we can do is -- I'm glad
9 you raised it, though, because it was one of the things
10 that we had put in the draft and were trying to decide, you
11 know, trying to keep things brief, is this worth mentioning
12 or not. And, so, we can put that in --
13 COMMISSIONER SZILAGYI: [Off microphone.] That's
14 great.
15 MR. PETERSON: -- make reference to that work.
16 CHAIR ROSENBAUM: [Off microphone.] Andy and
17 then Sharon.
18 COMMISSIONER COHEN: Great. Three quick points,
19 unusually quick for me, and thank you, Chris. Great work.
20 One is I just want to reiterate the point that
21 has been made. It would be great to talk, not just about
22 the percentage of children who are affected, but the

1 numbers, because they're really -- I mean, at the two
2 percent level, you're really talking about large numbers of
3 children who are, you know, whose families are spending
4 more than two percent of family income on a child, one
5 child. So, I think it's important to put the numbers in as
6 well as the percentage, because the percentages are low
7 though the ranges are quite wide. I mean, two to nine,
8 there's a big difference between two and nine percent.
9 But, the numbers are good. That's number one.
10 Number two, I think it's worth just saying one
11 time in a little place, this is in a year, you know, so
12 it's point in time, and especially because -- so, for some
13 families where the kids have chronic needs, that means year
14 after year after year after year their children's health
15 needs are more than two or five or ten percent of income.
16 But for the large percentage of kids for whom it's not
17 necessarily chronic, when you actually spread that over a
18 five- or a ten- or a 15-year period, you're talking about,
19 you know, many, many, many -- many more than two percent or
20 nine percent of families facing that in a given year. So,
21 I just think it's worth pointing out that this is in one
22 year that these numbers.

1 And then the third point, to sort of piggyback on
2 what Sara said, you know, we do focus a lot on the 200
3 percent of poverty sort of level, and I do think it is
4 important to point out that CHIP really primarily serves
5 kids under that level. But, I also just want to mention,
6 and I want to make sure this flavor remains in our work,
7 the majority of states, I think a lot more than -- you
8 know, a large majority of states have chosen to cover kids
9 over 200 percent of poverty, and the reality is the low
10 enrollment may be a factor of many children whose families
11 have incomes of 225 percent and 250 percent are more likely
12 to be in families where employer-sponsored coverage is
13 offered, not because you can really afford a health
14 insurance policy easily on 200 percent, you know, on a
15 family income at 200 percent of the poverty level.
16 That's today's situation, where employer-
17 sponsored insurance sort of is where it is, but it's not a
18 fixed fact. You know, there are trends going in the wrong
19 direction on that, number one.
20 And number two; we just want to reflect, I think,
21 that so many states have decided that it is important to
22 cover kids at higher levels than 200 percent. So, even

1 though the actual enrollment is small, it's still an
2 important sort of factor to consider.
3 CHAIR ROSENBAUM: [Off microphone.] Sharon.
4 COMMISSIONER CARTE: When Peter was talking about
5 the variability due to a child's condition, I was also
6 thinking about the variability in employment for families
7 and how it affects them in terms of whether they're in CHIP
8 or Medicaid or go up or down.
9 CHAIR ROSENBAUM: [Off microphone.] Any more
10 comments on the chapter?
11 [No response.]
12 CHAIR ROSENBAUM: All right. Why don't we then
13 move on to Ben's presentation on employer coverage? Thank
14 you very much, Chris.
15 **### Affordability for Children in Separate CHIP**
16 **versus Employer-Sponsored Insurance**
17 * MR. FINDER: Thank you. Today, I am here to walk
18 you through our analysis of out-of-pocket spending and
19 employer-sponsored insurance among low- and moderate-income
20 children.
21 I'll begin by describing the context and purpose
22 of the analysis, and then I'll briefly describe our data

1 sources and some of the methodology highlights and
2 underlying assumptions of this analysis.
3 And I will conclude by discussing the results,
4 which generally fall into two categories here on the slide:
5 the average out-of-pocket spending for children in separate
6 CHIP versus employer-sponsored insurance coverage and the
7 share of children with out-of-pocket spending exceeding
8 various thresholds.
9 Very briefly, Chris mentioned -- and
10 Commissioners will recall -- that part of our conversation
11 of the future of children's coverage has included a
12 discussion around the role of employer-sponsored insurance.
13 We estimate that employer-sponsored insurance is the likely
14 source of coverage for 1.2 million children currently
15 enrolled in CHIP if funding were to expire.
16 So our analyses in employer-sponsored insurance
17 have focused on covered benefits in employer-sponsored
18 insurance, and trends in coverage, including trends in
19 premium, and cost-sharing requirements.
20 To add to that body of work, we contracted with
21 the Actuarial Research Corporation to conduct an analysis
22 that examines what out-of-pocket spending would be for low-

1 and moderate-income children in employer-sponsored
2 insurance coverage. This probably sounds familiar to you
3 all. This analysis is parallel to the one that Chris just
4 described in his presentation on the draft of the March
5 report.
6 Before I get to our results, I want to highlight
7 some of the data sources that we used and some of the
8 methodology. A more detailed description of the data
9 sources and methods can be found in the appendix in Tab 3
10 of your meeting materials.
11 For this analysis, we used the same population
12 that was previously used. It's drawn from the Medical
13 Expenditure Panel Survey, and I won't mention much more
14 about that since Chris covered it broadly.
15 So we run this population through the cost-
16 sharing and premium parameters of the 2014 Kaiser HRET
17 Survey of Employer Health Benefits. Kaiser makes a public
18 use file available to researchers, and the survey includes
19 the responses from over 2,700 firms and statistical weights
20 that allow us to extrapolate to national averages.
21 There's one important assumption that we've made
22 here for the purpose of the model. We have estimated that

1 the additional cost of adding a child to an employer-
2 sponsored insurance plan is about 35 percent of the single
3 coverage premium, and this factor is based on an analysis
4 of benefit and covered expenses.
5 And finally, just like in the previous analysis,
6 we're looking at spending only on standard medical
7 benefits.
8 There are also some important limitations to this
9 analysis. First, I mentioned that the public use file
10 includes a nationally representative sample of firms;
11 however, it cannot be used to produce state-level
12 estimates. So that's one way in which this analysis
13 differs from the previous one.
14 Secondly, the estimates and results that I'm
15 about to show you represent average out-of-pocket spending
16 among low- and moderate-income children, if they were
17 enrolled in the sample plans.
18 Another important caveat to keep in mind is that
19 there are fewer lower income children or low-income
20 children enrolled in private health insurance relative to
21 Medicaid and CHIP, which means that few children might be
22 affected if states maintain current Medicaid and CHIP

1 eligibility levels.

2 And finally, it's worth noting that comparisons
3 of out-of-pocket spending can be difficult to interpret
4 because of the wide variation in employer-sponsored
5 insurance, particularly in plan design. I'll say a little
6 bit more about this in just a minute.

7 There are three key findings. First, children
8 face higher out-of-pocket spending in employer-sponsored
9 insurance plans than in separate CHIP plans.

10 Second, children at the lowest-income level, 133
11 to 150 percent of the federal poverty level, are more
12 likely to exceed various spending thresholds in employer-
13 sponsored insurance than in exchange coverage.

14 On the other hand, for children at 200 percent or
15 above 200 percent of the federal poverty level, the
16 opposite story is true; that is, children at the 200
17 percent of federal poverty level are less likely to exceed
18 various spending thresholds in employer-sponsored insurance
19 than exchange coverage.

20 So now we'll get into the actual data numbers and
21 the results. Children face higher average spending in
22 employer-sponsored insurance plans than in separate CHIP

1 plans. Average out-of-pocket spending, health spending,
2 was more than five times greater in employer-sponsored
3 insurance plans relative to separate CHIP plans. Children
4 face higher out-of-pocket spending on cost-sharing
5 requirements and premiums in employer-sponsored insurance
6 relative to CHIP.
7 On the other hand, out-of-pocket spending in
8 employer-sponsored insurance is lower relative to average
9 spending in the second lowest-cost silver exchange plan,
10 and much of the difference here can be attributed to
11 average out-of-pocket spending on health insurance
12 premiums.
13 We also want to know which children would face
14 the greatest financial burden by moving to employer-
15 sponsored insurance coverage. So, as you can see from this
16 table, more children face out-of-pocket spending in excess
17 of various thresholds in employer-sponsored insurance
18 relative to separate CHIP. No child exceeds thresholds for
19 5 percent or 10 percent of income in CHIP.
20 When we look at comparisons between employer-
21 sponsored insurance and the second lowest-cost silver
22 exchange plan, it's a little more interesting. More

1 children at 133 to 150 percent of the federal poverty level
2 face out-of-pocket spending in excess of various thresholds
3 in employer-sponsored insurance than in subsidized exchange
4 coverage. And here, on this slide, I have highlighted
5 those two analysis comparisons for you.
6 As I mentioned before, the opposite is true for
7 these children at 200 to 400 percent of the federal poverty
8 level.
9 A smaller share of children in employer-sponsored
10 insurance face spending above various thresholds relative
11 to exchange coverage.
12 So I mentioned this earlier, and I'd like to come
13 back to this point again. Comparisons to employer-
14 sponsored insurance can be complicated to interpret because
15 employer-sponsored insurance plans vary widely and
16 particularly when it comes to plan design. Some other
17 variation occurs across certain firm characteristics, such
18 as industry type or firm size, as measured by the number of
19 employees.
20 For example, in this analysis, we found that low-
21 and moderate-income children face lower out-of-pocket
22 spending than plans offered by large firms compared to

1 small firms.

2 We also observed that employers offer plans at a
3 wide range of actuarial values. You will recall that the
4 term "actuarial value" refers to the percentage of covered
5 benefits paid for on average by a plan for a particular
6 individual. In this analysis, we found that employers
7 offered plans with actuarial values that range from less
8 than 60 percent to 95 percent or higher, and in general, we
9 found that 55 percent of plans for low- and moderate-income
10 children would have an actuarial value, an effective
11 actuarial value of 80 percent or higher.

12 So, with that, I'll conclude. We hope that this
13 provides you with a better understanding of what employer-
14 sponsored insurance looks like for low-income and moderate-
15 income children, and I look forward to any questions you
16 might have.

17 CHAIR ROSENBAUM: Questions? Comments?

18 Yes, Kit, and then Peter.

19 COMMISSIONER GORTON: So let's see if I cannot
20 break this down. So, Ben, I guess I'm struggling with your
21 valiant, but I'm not sure successful attempt to
22 characterize any consistency across employer-sponsored

1 coverage because I think that coming up with even a
2 comparative plan, if you think about the difficulty under
3 the ACA that the regulators had in getting on a state-by-
4 state basis, a representative comparative plan to use just
5 to create the exchanges, there is so much variation there,
6 and the rules are so different.
7 So it matters whether it's a self-insured plan
8 that is regulated under ERISA or whether it's a fully
9 insured plan. It matters whether it's a PPO, which is what
10 employers who are buying benefits in order to attract high-
11 quality employees like to buy. The cost-sharing and out-of-
12 pocket in those plans are substantially different versus an
13 HMO-style plan with a much narrower network.
14 It matters what the network configuration is. It
15 matters whether the benefit to sign allows balanced
16 billing. It matters what happens when people go out of
17 network or when providers use -- sort of embedded
18 providers, like anesthesiologist and emergency room doctors
19 and other things who are working in an in-network facility
20 but who are in fact out of network, and so that the member
21 may be exposed actually to charges. Those things matter.
22 The level of employer subsidy -- and of course,

1 even talking about employers -- we're talking about
2 employers. We're talking about unions. We're talking
3 about other trust funds that buy insurance. We're talking
4 about plans purchased by government agencies, which are
5 often regulated in very different ways.
6 And so I was thinking when Sharon was talking in
7 the previous section about all of the variability in family
8 configurations and the amount of difficulty that means in
9 coming up with what I think Sara referred to as an
10 archetypal sort of model, for me I'm not convinced that
11 what you're using as your archetypal employer-sponsored
12 plan actually exists in reality for anything more than a
13 very small number of people.
14 As I read through some of the comparisons in
15 terms of premium, the other comment I want to make -- and
16 then I'll shut up -- is we talk about the premium that's
17 paid by the families, and that may control whether or not
18 they use the insurance or not. We see large numbers of
19 employers who offer insurance but have very low uptake. So
20 you can think about a large super market chain in New
21 England that has 500 employees, offers insurance. They
22 have four people who participate, and it's because nobody

1 else in the place considers the coverage to be affordable.

2 And so I think that it is important for the

3 purposes -- I guess what I want to say is where the

4 employer is providing coverage, if we're talking about

5 premium, I think it's important in a discussion that the

6 actuarial value of employer-sponsored plans to capture the

7 full premium that's paid. That includes the 70 or 80 or 90

8 percent share that the employer may be providing.

9 And so I found it unsettling to see sort of side-

10 by-side comparisons of premium and benefit without some

11 very explicit disclosure that there's a huge employer

12 subsidy, and I think one of the issues that we get into

13 when we compare employer-sponsored coverage with

14 government-sponsored coverage is that the money has got to

15 come from somewhere. And so if you talk about replacing

16 CHIP with employer-sponsored coverage, then essentially,

17 what you're potentially doing is shifting a huge burden

18 onto employers who may or may not be willing to undertake

19 that and may or may not be able to undertake that burden.

20 CHAIR ROSENBAUM: Rather than the case coming up

21 to the CHIP level of protection.

22 COMMISSIONER GORTON: Yes, because to be able to

1 provide a benefit -- and most employer-sponsored coverage
2 is underwritten largely with an eye towards an adult
3 working population, and dependent coverage is -- the
4 dependents are 15 percent, and so, you know, you get a
5 little more wiggle room there. If we're starting to talk
6 about a huge population of children, particularly children
7 with special health care needs or children with acute
8 catastrophic events, then if you get that pool much richer
9 in the employer-sponsored case than what you're going to
10 see -- and we've struggled with this in the exchanges -- is
11 to try and keep the actuarial value correct. You start to
12 end up with creep either on premium or on out-of-pocket or
13 both.
14 CHAIR ROSENBAUM: Norma.
15 COMMISSIONER ROGERS: You know, in the state of
16 Texas, which has the highest uninsured children, people
17 that work in the state system, they have employer
18 insurance, but I can guarantee you that the majority of
19 that administrative staff or secretaries or housekeepers
20 are using CHIP because they cannot afford what it costs to
21 pick up the employer insurance. It is just out of their pay
22 range.

1 When you're talking about someone that has --
2 let's say there are three children and a single parent --
3 that's four -- and they're making $25,000 a year, I mean,
4 really? Do you think they're going to be able to pick up
5 the cost? It's not going to happen. So what's going to
6 end up happening is that we're going to have even more
7 uninsured children than we've ever had before.
8 CHAIR ROSENBAUM: Peter.
9 COMMISSIONER SZILAGYI: This is a little bit
10 related to one point that Kit was making, and if I'm way
11 off base, it's because I arrived late last night from the
12 West Coast, and so I need another coffee break, I think.
13 As I'm thinking about when we're considering how
14 to design legitimate health insurance program for low-
15 income children, family -- and I may be misinterpreting
16 these tables, actually, all of a sudden, but families have
17 to make the decision based on their family constituents.
18 So the majority of families, I think in CHIP,
19 have two or more children, not one, yet we're presenting
20 these tables as the impact of a single child. So I'm
21 wondering whether there is sort of a simple way of
22 modeling, and we know the distribution, I think, of the

1 number of children in families in the CHIP population. So
2 what percentage of families would hit 5 percent of their
3 income, because they have two children, if they enroll two
4 children? I mean, it's just simple math, in a way, and it
5 doesn't take away anything from what we're presenting in
6 the tables because I think we're presenting kind of truth
7 from what the models show.
8 But when families are making their decisions,
9 they're not kind of making it based on the one child, but
10 the children that they have, or am I totally
11 misinterpreting this?
12 COMMISSIONER CARTE: Right. That's what I was
13 trying to say at the beginning, Peter, although in our CHIP
14 in West Virginia, I think our average child is slightly
15 under 2, like 1.8 or something like that. Even so, it's
16 nearly a doubling of the premium assumption that's in the
17 model.
18 COMMISSIONER SZILAGYI: But we could show
19 additional tables. X percentage of families, because they
20 have two children, would be at 5 percent, and X percent of
21 families, because they have three children, would be at 5
22 percent. Roll that together in what percentage of families

1 if they enrolled all their children.

2 CHAIR ROSENBAUM: Well, but what I hear you
3 saying, which I think is a very excellent point -- and it
4 came up for Sharon as well -- is that we might want to
5 really make an effort to show the child impact, the family
6 impact, with some key illustrative examples, whether
7 they're all complex, involved tables or whether we simply
8 really draw the point out for people that where you're
9 seeing individual child comparisons, that's really only the
10 starting point because families have -- many families have
11 more than one.

12 Alan.

13 COMMISSIONER WEIL: I want to take an overall
14 comment in a somewhat different direction, which is I think
15 you present this information as companion to the prior
16 chapter. In the prior chapter, because silver plans are
17 actuarially in a fairly small band, what dominates the
18 question of whether a family -- setting aside the one-
19 child, two-child issue, which is really important -- what
20 dominates whether or not a family shows up in the 2, 5, 10
21 threshold is how sick, what the utilization is, as well as
22 the family income.

1 Here, you have this third variable, which is the
2 benefit design of the plan, and you put it sort of as the
3 last, but again, from sort of a policymakers perspective, I
4 would think that degree of variability is a really big
5 deal.
6 It's funny because when I saw Table 4, which does
7 it by employer size, you say, "Wow! There are these
8 differences," but, of course, the differences within each
9 of those employer-size categories is much larger than the
10 differences across.
11 Similarly, you've got this reversed income
12 gradient from the exchange coverage, which led me to a
13 somewhat different direction to at least consider. I don't
14 know. I don't know how it looked, but it does feel to me
15 that presenting this almost more using benefit design as
16 the primary dividing characteristics, in other words, for
17 families in an employer coverage at the 90 to 95 percent
18 actuarial value, which is actually 12 percent of the plans
19 according to Table 5, this is how many are likely to exceed
20 these thresholds. But if you're in the 70, 75 percent,
21 which is also 15 percent of families, the share that are
22 going to exceed this threshold is much larger.

1 So to sort of capture, what I'm trying to get at
2 is the plan design is so dominant in whether or not you
3 exceed the threshold, presenting the results by actuarial
4 value, not the averages as you've done, but the share that
5 exceed seems to me to do a better job of explaining how
6 important that variable is relative -- and because it's
7 unique to ESI relative to CHIP or exchange, it would
8 highlight what I think is the most important finding.
9 CHAIR ROSENBAUM: Do you have a question?
10 COMMISSIONER DOUGLAS: Well, just building, I
11 think what Alan's saying is really important in terms of
12 the comparison to any of these charts where you compare it
13 to the lowest-cost plan, it really, you know, needs to be
14 highlighted that you're only -- if you start breaking it
15 apart the way Alan said, then you get a completely
16 different outcome.
17 CHAIR ROSENBAUM: Yes, and I agree completely
18 that tying things to actuarial value has the effect of
19 both, I think, highlighting the critical point we're making
20 and leveling the playing field a little bit so that, going
21 to Kit's point, you don't get so overwhelmed by the noise
22 inside of a benefit design that you missed the big point,

1 which is employer -- I mean, it seems to me that the big
2 point in all of this over and over again is that in CHIP we
3 see a very child-conscious approach to developing coverage.
4 You know, families should not have to pay much because we
5 don't want them to have to make choices that are a
6 financial burden to families or skimp on health care.
7 Whereas, in the case of employer coverage and in the case
8 of exchange coverage, the fundamental purpose is very
9 different. It's not a child-conscious-designed system.
10 It's a system in which what we're trying to do is get some
11 level of coverage to everybody in a family. And employers
12 do the best they can, and they test different designs, but
13 they're, you know, trying to take what they can buy and
14 spread it as much as they can.
15 And, really, the only other source of financing
16 we have that has managed to be child-conscious within a
17 much bigger framework is, of course, Medicaid, which is
18 extremely child-conscious, but because Medicaid is an
19 individual entitlement program and not a global contract,
20 the flexibility to think by subpopulations is greater.
21 And so I actually found the employer work
22 extremely instructive, and there should be -- and we'll get

1 to this, of course, in the last part of the morning, but I
2 think it's a matter of taking what you've been able to show
3 and just repackaging it, and then you see these thematic
4 commonalities between the prior chapter and this one, or
5 prior material and this one.
6 COMMISSIONER GORTON: Can I just build on the
7 child-centeredness, or whatever term you used? The other
8 piece of it, in addition to benefit design, is how the
9 networks work. So the CHIP plans have been built with
10 specific intent to provide networks which serve children's
11 needs. And while it is certainly true that in employer-
12 sponsored coverage you have to provide access to high-
13 quality services that meet children's needs, there's far
14 less focus on it and far less attention to certain segments
15 of the delivery system.
16 So, for example, pretty common to run into
17 behavioral health providers who will say, "I take Medicaid,
18 and maybe I take one of the CHIP plans or two because
19 that's important." But they don't participate in terms of
20 commercial coverage. And the services offered in employer-
21 sponsored coverage -- and this is changing, but, again,
22 it's a patchwork, and it changes place by place. But, for

1 example, ABA services for kids with autism may or may not
2 be available in employer-sponsored coverage or may be
3 available but hard to access or may be available and
4 accessible but require significant out-of-pocket on the
5 part of the family, particularly if you're like Leanna and
6 you have two kids, God forbid, who need a little extra help
7 getting by.

8 And so, you know, I think it's a different
9 animal. Employer-sponsored health coverage was created for
10 a different purpose, and I think it's important to call
11 that out to people as you make comparisons.

12 COMMISSIONER CARTE: I just wanted to note -- and
13 this came not from Ben's chapter, but from the fact sheet
14 that MACPAC issued earlier in the month on employer-
15 sponsored insurance. I think it's pretty noteworthy, I
16 mean, I think we're all aware of the trend among employers
17 to shift more of the cost to their members or their
18 families. But it's pretty striking when it noted that 84
19 percent of the private sector employees were enrolled in
20 plans with a deductible, and that's up from 48 percent in
21 2002. That's quite a shift. And so the number of children
22 in low-income families that face a deductible on average

1 has really gone up, and you have to question how much value
2 it has to a family when they have, you know, Swiss cheese-
3 type coverage, even though acknowledging that there are
4 protections for the preventive services in the ESI plans.
5 And to Norma's point, we're seeing in states like
6 mine and yours that are struggling with economies, West
7 Virginia for a long time has had an 80-20 share for its
8 public employees in its insurance plan. But now for the
9 first time, they're talking about going to 75-25. So those
10 are very serious trends and don't bode well for the kinds
11 of issues that Kit was raising.
12 COMMISSIONER SZILAGYI: A very minor point.
13 Piggybacking on what Alan was talking about in terms of
14 potentially new analyses that are stratifying by the
15 actuarial value of the employer-sponsored plan; Table 5
16 shows the share of plans. I don't know how that relates to
17 the share of people or children in plans. So I kind of
18 agree with classifying it by plan, but somewhere overlaying
19 it with what proportion of the population does that affect.
20 CHAIR ROSENBAUM: All right. Well, thank you,
21 Ben, for struggling with this complicated question.
22 Why don't we now move to the last part of the

1 morning, which is an overview of where we have gotten
2 ourselves to and sort of what's on our minds.

3 ### The Commission's Work on Children's Coverage and
4 Next Steps

5 * MR. PETERSON: All right. Thank you.
6 In the prior two sessions, we presented our
7 latest research on the affordability of children's
8 coverage. These are two pieces in the large body of
9 research we have conducted or assembled over the past
10 several months, even years, to help inform your discussions
11 now in 2016, considering options for the future of
12 children's coverage.
13 The Commission has previously stated that the aim
14 is to ensure that children have access to high-quality
15 health coverage that is affordable to families and
16 integrated with the fully array of coverage options. And
17 at the same time, the Commission has acknowledged the
18 tradeoffs with federal and state costs and other important
19 considerations.
20 The Commission's earliest work focused first on
21 the consequences of an abrupt end to CHIP after fiscal year
22 2015 when funding was then scheduled to run out. And in

1 June 2014, the Commission recommended that federal funding
2 be extended by two years.
3 But Commissioners have made clear in the past
4 that the discussions going forward, as you move to
5 consideration of options, are not to be about only children
6 in CHIP alone, but to consider options that smooth
7 transitions and cliffs between programs for low- and
8 moderate-income children.
9 So today we want to in this session begin by
10 briefly recapping our early work on children's coverage,
11 much of which led to the Commission's recommendation to
12 extend CHIP through fiscal year 2017. When that
13 recommendation was made, we said more time was needed for
14 analyses to inform how to best design coverage, and since
15 then, of course, we've compiled research and presented and
16 discussed what is knowable from those analyses. And now I
17 want to summarize that work one more time, and then we'll
18 turn to how we move forward in 2016 and your discussion.
19 So talking about evidence and recommendations to
20 date on children's coverage, in March 2014, in that report,
21 there were two recommendations.
22 First was that the Congress should eliminate CHIP

1 waiting periods, and you see the criteria that were used in
2 that decision about continuity of coverage, that waiting
3 periods lead to uninsurance, have not been shown to reduce
4 crowd-out based on the literature, and are inconsistent
5 with Medicaid and exchange eligibility policies.
6 And then we had a second recommendation at that
7 time that CHIP premiums below 150 percent of poverty should
8 be eliminated, and that was based on research that showed
9 that below 150 percent of poverty, premiums have very
10 little effect on crowd-out and just simply increase
11 uninsurance, while above 150 percent of poverty, the
12 story's a little different. So that's a summary of the
13 recommendations we had at that point.
14 And then in June 2014, as we've discussed, there
15 was the recommendation to extend CHIP funding for two more
16 years, again, to enable two additional years of transition,
17 and acknowledging that you were trying to take into account
18 all of these issues about adequate affordable coverage,
19 equitable treatment of states, appropriate use of public
20 dollars, smooth transitions across sources of coverage. So
21 these are the things that the Commission said we want to be
22 thinking about moving forward in terms of options, and that

1 if more time was needed to ensure reforms are in place,
2 further extending the transition should be considered.
3 Some of our findings on the effects of coverage
4 on uninsurance at that time was that, without an extension
5 of CHIP, 3.7 million children would have lost their
6 separate CHIP coverage in 2016; and of those, you see the
7 numbers, but 1.1 million would become uninsured. And at
8 that point, children in Medicaid expansion CHIP would not
9 lose coverage because of the maintenance of effort in
10 effect through fiscal year 2019.
11 On the affordability front, in our early work
12 looking at the effects, you see some of the results there
13 about how much more families would face in employer-
14 sponsored coverage in that out-of-pocket spending in
15 exchange coverage would be significantly higher,
16 particularly for children with special health care needs;
17 and then to Sharon's point mentioned earlier, that
18 decisions to enroll are affected by the cost of coverage
19 relative to other expenses, relative to other things going
20 on in the family.
21 And then we followed up with the more recent
22 research that we've talked about here today in terms of

1 what families would face if the children were moved from
2 separate CHIP to exchange coverage, that, as we mentioned
3 in the prior session, some children in every state would
4 face expenditures above 5 percent of income, which is
5 prohibited by CHIP now, and the other points we already
6 discussed earlier today.
7 Now I'll turn it over to Joanne.
8 * MS. JEE: Thanks. So to look at the evidence on
9 adequacy of benefits, we've discussed that most CHIP,
10 Medicaid, exchange, and employer-sponsored plans generally
11 cover major medical benefits. But there are some
12 differences between Medicaid and CHIP and exchange plans
13 that we want to just highlight for you again this morning.
14 One such area is with pediatric dental services.
15 These benefits are covered in Medicaid and CHIP and are
16 considered essential health benefits for exchange coverage.
17 The research shows that about 35.7 percent of exchange
18 plans provide embedded pediatric dental benefits, but that
19 dental benefits are offered as a stand-alone insurance
20 product in most exchanges, and to purchase that insurance
21 product would require separate premiums from those
22 selecting that coverage.

1 A second area where there are some differences is
2 in audiology exams and hearing aids. Again, these services
3 are covered in most Medicaid and CHIP programs, but in
4 looking at the exchange benchmark packages, 37 percent
5 cover audiology exams and 54 percent cover hearing aids.
6 And as a reminder, the exchange health plans or the QHPs
7 are based on the exchange benchmark packages.
8 And to mention just a few additional areas and
9 what we've learned about them over the last several months,
10 I wanted to mention provider networks. Staff's examination
11 of the issues surrounding provider network adequacy,
12 including a convening of a roundtable of experts, found
13 that, you know, indeed there are concerns about the
14 adequacy of exchange networks, especially for children with
15 special health care needs. However, there's thus far
16 little research on the extent of differences, network
17 differences between Medicaid, CHIP, and exchanges and the
18 effect of any such differences on children's access to
19 care. Roundtable participants noted several other areas,
20 but also stressed the importance of monitoring networks and
21 having appropriate access measures.
22 We also looked at the recent transition of

1 stairstep children, and as a reminder, the ACA expanded the
2 minimum Medicaid eligibility level for children to 138
3 percent of FPL, which meant that states that had been
4 covering children age 6 to 18 up to this income level in
5 separate CHIP were required to transition coverage for
6 those children from separate CHIP to Medicaid. And so this
7 is the group of children commonly referred to as the
8 "stairstep children."

9 In interviews with stakeholders in ten states, we
10 learned that states implemented a number of strategies to
11 facilitate smooth transitions, such as ones focused on
12 ensuring or promoting continuity of care over the course of
13 the transition. Interviewees also described a number of
14 challenges experienced by states and families, for example,
15 four states, in preparing information systems and
16 technologies that were needed.

17 So, in general, taking into account the efforts
18 of the states to smooth the transition as well as the
19 challenges experienced, overall the stakeholders generally
20 described the transition as having gone smoothly. So the
21 stairstep transition may be instructive in many ways for
22 any future large-scale transition of children's coverage.

1 Much of the evidence that we've been highlighting
2 for you this morning focuses on children with separate CHIP
3 coverage, but children are enrolled in Medicaid expansion
4 CHIP as well, and those children could face some changes in
5 coverage in coming years. As Chris mentioned, with the
6 maintenance of effort, states must maintain the children's
7 eligibility standards through fiscal year 2019. So in
8 states with Medicaid CHIP expansion -- Medicaid expansion
9 CHIP, excuse me, and if there's no extension for CHIP
10 funding beyond fiscal year 2017, those states would
11 continue to provide that Medicaid coverage to those
12 children, but would receive the regular Medicaid matching
13 rate rather than the enhanced CHIP match. And beginning in
14 fiscal year 2020, states may roll back their Medicaid
15 eligibility levels unless the MOE is extended.
16 So if all states rolled back eligibility levels
17 for children in Medicaid to the maximum extent possible,
18 which would be to about 138 percent of the federal poverty
19 level, an estimated 2.3 million children would lose
20 Medicaid expansion CHIP coverage. And of those, about
21 700,000 are projected to become uninsured. So,
22 Commissioners, as you think on options for coverage, this

1 group of children who are currently in Medicaid expansion
2 CHIP are a group that you might consider.
3 So we've talked about the Commission's analyses
4 thus far and what they tell us about children's coverage.
5 At this point, the Commission's task for the remainder of
6 2016 really turns to drawing upon these analyses to assess
7 options for coverage for low- and moderate-income children
8 going forward. We're going to get to these options in just
9 a moment, but before we do that, I wanted to review the
10 current context for children's coverage.
11 So to do that, we are going to look at this
12 figure, and this is something that Chris has been
13 developing and refining over the last several months but I
14 get to present. So to orient you to this chart, if you
15 look across the X axis, there are three groups of children
16 by age: infants, the younger kids one to five years old,
17 and then the school-aged children six to 18 years old. And
18 there's a vertical bar representing the eligibility level
19 for each state, and then up the Y axis we have income as a
20 percent of the federal poverty level.
21 So the bars that are present on this chart right
22 now, these dark -- they look black but they're navy blue --

1 represent states' Medicaid eligibility levels pre-CHIP.
2 And so you'll see that the children five years old and
3 under are covered up to 133 percent or 138 percent of FPL
4 with the disregard, and that the older children, the six-
5 to 18-year-olds, are covered up to -- or are eligible up to
6 100 percent of FPL.

7 CHAIR ROSENBAUM: I'm sorry. This is without
8 regard to the stairstep children, right?

9 MS. JEE: So far, yes.

10 CHAIR ROSENBAUM: Okay.

11 MS. JEE: Pre-CHIP.

12 CHAIR ROSENBAUM: Pre-CHIP [off microphone].

13 MS. JEE: So with the enactment of CHIP, several
14 states implemented Medicaid CHIP expansion, and those
15 states are represented here with the green bars with the
16 blue diagonal stripes. And, of course, you'll see that
17 there continues to be substantial variation among the
18 states in what their eligibility levels are for the
19 different age groups of children.

20 Right, and if you look at the white-dashed
21 horizontal line, that line is at 138 percent of the federal
22 poverty level, and you'll see that for the older kids,

1 those 16- to 18-year-old kids, they are now completely
2 covered under that line. And so that group of children,
3 who are the green and blue diagonal bars, those are the
4 stairstep kids. And, of course, several states have
5 implemented separate CHIP programs, which are shown here in
6 the green bars. And the theme of variability continues.
7 So that's CHIP. And, of course, we are now in a
8 post-ACA landscape, so we can add more to this table or to
9 this chart. So here what we've added are the exchange
10 subsidies for families between or individuals between 100
11 and 250 percent of federal poverty, and the yellow
12 represents cost-sharing subsidies as well as premium tax
13 credits or the premium subsidies available to individuals
14 on the exchange if they're not eligible for Medicaid or
15 CHIP.
16 CHAIR ROSENBAUM: Just to be clear, so what
17 you're showing us is that in those states that go higher,
18 they tend to go higher as separate CHIP states, as opposed
19 to the Medicaid expansion CHIP. If a state's going to go
20 high, it's tending to go high within an independent
21 program.
22 MS. JEE: Yes. So you can see, you know, there's

1 the bar that goes up to, you know, 400, and there are some
2 that go to over -- right up to 300 and, you know, even 350.
3 And those are with the green bars, which are separate CHIP.
4 Okay. So once individuals get to 250 percent of
5 the federal poverty level, they're no longer eligible for
6 the cost-sharing subsidies, but they remain eligible for
7 the exchange premium tax credits or the premium subsidies.
8 Again, if they're not eligible for Medicaid or CHIP -- and
9 that is shown here with the orange band.
10 So, really, the point of this slide is to show
11 the point about variability that Peter was making earlier,
12 which is that for individuals above -- or children above
13 138 percent of the federal poverty level, depending on your
14 age and your income and what state you live in, you might
15 be covered in Medicaid, you might be covered in separate
16 CHIP, or you might be eligible for exchange subsidies.
17 And so that, Commissioners, is the context in
18 which you all consider your options for children's coverage
19 moving forward.
20 CHAIR ROSENBAUM: I could spend like another four
21 years on this slide. It's a fantastic slide.
22 MS. JEE: Don't worry. I'm sure --

1 CHAIR ROSENBAUM: It's a lot to absorb. It's
2 telling a lot of stories, actually.
3 MS. JEE: Okay. So, with that, let's turn just
4 for a moment to the broad options that have been discussed
5 thus far.
6 The first is maintain current law, and under
7 current law, CHIP funding expires at the end of fiscal year
8 2017, and as we've been discussing, if CHIP funding ends,
9 some children would enroll in employer-sponsored coverage,
10 some would enroll in Medicaid, and -- I'm sorry, in
11 employer-sponsored insurance, and some would become
12 uninsured.
13 The second option is to enhance exchange coverage
14 to address the concerns with affordability and adequacy of
15 benefits that have been discussed over the last several
16 months. And there are, of course, a number of ways that
17 this could be done, such as further subsidizing premiums or
18 cost sharing.
19 A third option is to expand mandatory Medicaid
20 for children, and this would mean establishing a new
21 mandatory minimum eligibility level for children to some
22 level higher than the current level of 138 percent of FPL.

1 The next option is to replace CHIP with a new
2 bridge plan, and this bridge plan would smooth the cliffs,
3 or the differences, in affordability and adequacy of
4 benefits for children who would move from one coverage
5 source, such as Medicaid, to another coverage source, such
6 as the exchange, or from CHIP to the exchange.

7 And the fifth option on this slide is to extend
8 CHIP funding beyond fiscal year 2017 to some other year or
9 perhaps indefinitely.

10 And, I wanted to acknowledge that within each of
11 these options, there are a number of key decision points
12 and design features to consider, but for this morning's
13 purpose, I just wanted to remind you what options have been
14 discussed thus far.

15 Commissioners, as you think about the next steps
16 for 2016, the goal is to have a package of recommendations
17 ready for the new Congress in 2017. Twenty-seventeen is
18 also the time at which the question or the issue of CHIP
19 funding will resurface for policymakers.

20 To meet the 2017 goal, the following would need
21 to occur. In winter and spring, you all will need to
22 consider the options for coverage for low- and moderate-

1 income children so that in the fall, the preferred option
2 can be refined and the rationale for it can be finalized.
3 By fall, we would also obtain a cost estimate for the
4 option. Then in December 2016, there would be a vote on
5 the final package of recommendations.
6 So, this lays out the analytic work so far, and
7 lays out for you sort of the key next steps for the coming
8 year. We look forward to your discussion and would be
9 happy to respond to any questions you might have.
10 CHAIR ROSENBAUM: Thank you both. Can I ask one
11 favor, which is to put up that unbelievable slide as we're
12 sitting here talking, because I think having the
13 visualization in front of us is a good thing.
14 So, I think as we discuss this, there are sort of
15 a couple different issues. One is the larger issue of how
16 we want to -- it's nice to know the child health policy is
17 very simple, right?
18 [Laughter.]
19 CHAIR ROSENBAUM: So, I think there's the larger
20 question of how we want to come at the issue, how we're
21 going to express ourselves at sort of the highest level to
22 Congress, what kind of discussion we want to have with

1 Congress at this point. And then within that, the more
2 specific questions of, you know, if we're having the
3 discussion at the highest level, basically, what do we see
4 as logical steps that Congress might consider, and from
5 that, of course, do we have real recommendations to make.
6 So, with that, I now open the floor. Andy, and
7 then Toby.
8 COMMISSIONER COHEN: Thanks, Sara. I just want
9 to make a very big picture point, and I hope you don't --
10 it is not perceived as fighting the hypothetical, but I
11 just want to make sure in terms of framing that we keep
12 this in mind.
13 The issue that we face sort of immediately and
14 concretely is about sort of the potential termination of
15 CHIP and kind of what to do about that --
16 CHAIR ROSENBAUM: And 2019 is a perfect storm.
17 COMMISSIONER COHEN: Right. But -- exactly,
18 where the MOE and then, right, then the MOE ends for
19 Medicaid. But, the bigger picture is that we are a sort of
20 natural place, because Medicaid covers so many children and
21 there is no other program that has real -- you know, the
22 other major program that covers children besides Medicaid

1 and CHIP is employer-sponsored insurance, where we don't
2 have sort of a policy making -- the same kind of sort of
3 policy making tools. So, we are the natural place to be
4 thinking about coverage for kids sort of in general and not
5 just related to these two specific things. And, of course,
6 perfect storms are times to put lots of stuff on the table,
7 but to stay focused.

8 So, I just want to remind us, and maybe remind
9 myself, coverage is a means to an end and the end is health
10 care and health, really. I mean, the end is child health.
11 And, so, while traditionally Medicaid has been largely
12 about just buying access to a system that exists, more and
13 more, we understand that the payment programs can really
14 drive and either support or impede the actual sort of
15 system that you get access to, and that can have an impact
16 on health. And, of course, we all know it has not a total
17 impact on health, because lots of other things have a huge
18 impact on child health, but the health care system has some
19 impact, too, and potential impact.

20 So, I just want to make sure that, as we're
21 talking about this, that we don't start too narrow and
22 really sort of think about the big picture of kind of what

1 is our policy on child health. It's not just affordability
2 that is critical and it's -- you know, whether kids
3 actually have coverage is a critical first step that we
4 can't ignore, but it is not the only thing that I think we
5 should be considering in this discussion.
6 CHAIR ROSENBAUM: [Off microphone.] Toby.
7 COMMISSIONER DOUGLAS: Umm, and with a question
8 on analysis. But, I wanted to just -- since I'm the new,
9 one of the new ones, and not knowing what you talked about
10 before, what this chart doesn't show is kind of the
11 evolution of how CHIP has changed as a program. And, I
12 think of that in my former role in California. You know,
13 CHIP started with very different benefit requirements, very
14 different eligibility, even some of the, you know,
15 principal Medicaid policies, like FQHCs and other things,
16 changed.
17 So, when I think of CHIP now, I think of it as
18 very much Medicaid for higher-income, and it was a lot of
19 kind of our policy discussion in California as we evolved
20 and moved from a separate CHIP to a combination, and it was
21 also coupled with the consumer experience and the movement
22 between programs and moving up and down from different CHIP

1 to Medicaid and what was the value of that when the program
2 was pretty much the same.
3 And, so, the question from an analytical, as we
4 think this through, is has there been thought to any
5 analysis on -- I know it would be more qualitative, but of
6 this movement in the value as we think about policy
7 decisions of separate CHIPs in a world where the rules are
8 pretty much the same of Medicaid.
9 Now, financing, but we have on Medicaid different
10 financing, like we know with the Medicaid expansion and 100
11 down to 90. So, yeah, the financing is different, but the
12 benefits, is it really that much different_?
13 So, it's both a policy, clearly taking my
14 California experience, but what analysis could help us on
15 framing that beyond, you know, on a national level, how
16 that's played out in state by state.
17 CHAIR ROSENBAUM: Penny.
18 COMMISSIONER THOMPSON: I'd just build on that
19 point and make a couple of others, too, which is the
20 question of what are the standards by which options are
21 evaluated. You know, what are the criteria by which you
22 would make a judgment that one particular option would be

1 preferable to another particular option, and does CMS know
2 the development of those standards by which you would
3 evaluate these different choices is itself its own kind of
4 project to decide what matters and what's relevant.
5 And I think Andy's point about what's the
6 ultimate aim and, you know, what supports getting to that
7 ultimate aim, and Toby's point about to what extent is
8 there some sort of unnecessary complexity in the system
9 that introduces challenges and barriers to the consumer
10 experience, to the Chairman's earlier point about you've
11 got to think about families and what does this do to the
12 overall family experience and so forth.
13 So, there's a lot of different things that we
14 could be talking about with respect to what really matters
15 in terms of impacting take-up of coverage, you know, true
16 access to care, and then, ultimately, better health through
17 that.
18 The other point that I would just make is,
19 Joanne, you made the point -- not to argue about maybe past
20 research that's already been done and accepted -- but you
21 made the point that maybe the transition of the stairstep
22 kids could be instructive, and I'm a little skeptical about

1 that. And, I suppose it sort of in the end depends on what
2 ultimate option you're talking about transitioning to.
3 But, I think that the idea of transitioning CHIP kids to
4 Medicaid is an entirely different animal than talking about
5 transitioning CHIP kids to private coverage, to multiple
6 other programs, or even to programs that introduce new
7 challenges for the family in a way that I don't think CHIP
8 to Medicaid transition introduces.

9 And, so that just also leads me to my third
10 point, which is I think in any of these conversations, we
11 need to, in addition to keeping an eye on kind of these
12 policy questions and choices, be thinking about transition
13 and implementation and what that means from the point of
14 view of individuals and families, but also payers and
15 providers and plans and states and giving ourselves a
16 little bit of a sense as to whether or not from a
17 legislative standpoint there needs to be, you know, better
18 and more appreciative funding authorities, steps that might
19 be needed in order to make sure that that implementation,
20 transition, whatever it is, occurs as best as possible.

21 CHAIR ROSENBAUM: Kit.

22 COMMISSIONER GORTON: I think, building on

1 Penny's question about criteria, I think another piece of
2 that has got to be the question of who's going to deploy
3 the criteria. We look at other segments of the population,
4 states have been given wide latitude to create specialized
5 programs. There are programs that have been created for
6 special populations. The options that are available to
7 seniors range everywhere from PACE to Medicaid Advantage,
8 D-SNPs, and now we have the duals demonstrations.
9 And, so, I guess my first reaction to Slide 14
10 was that it felt really constrained in terms of -- I don't
11 know that I believe at this point, and maybe I'll become
12 convinced of this, that the Commission should recommend one
13 single option for everyone. It may be that we want to
14 recommend a range of options that states, in consultation
15 with CMS, might want to consider in order to, you know,
16 address these -- in order to address the child population.
17 I guess I would ask, with respect to research to
18 drive that question, we've heard about these groups of kids
19 who would be disadvantaged in the exchange environment, the
20 kids with chronic illness and then the kids with
21 unexpected. I'd be interested in seeing data in terms of
22 the relative weights of those, the relative expenses of

1 those. Are there programmatic designs that could address
2 those? Could you come up with some sort of reinsurance cap
3 for kids to deal with unexpected, catastrophic black swamp
4 kind of events, and then deal with kids with chronic
5 illness? And what does the insurance pool look like if you
6 take the kids with chronic illness and pull them out?
7 I think we have tended to embrace a same for
8 everybody, you know, Medicare for all kind of mindset, and
9 I think our experience with the seniors has shown us that
10 some diversity of programmatic design can be useful. We
11 ought to at least entertain it for children.
12 EXECUTIVE DIRECTOR SCHWARTZ: I just want to say
13 from a staff perspective is that those options on the slide
14 are not meant to constrain you, but rather to have
15 something there for you to start with. And I can very well
16 imagine that you might want to pick different things for
17 different income ranges or different groups of kids. But,
18 better to put something there than say, so, what do you
19 guys think?
20 CHAIR ROSENBAUM: Yeah, and importantly, just to
21 note that the conundrums that we're dealing with, what
22 criteria, you know, are there uniform approaches that can

1 just be, you know, recommended, or are we really looking at
2 a much more pluralistic set of problems that really need to
3 undergird our recommendations, these have come up over the
4 last year, as well.
5 In fact, one of the reasons why we ended up
6 recommending the two-year extension of CHIP was precisely
7 because we realized that there is so much more going on
8 here than just the question of whether you continue this
9 particular pot of money. You know, is this a moment,
10 because of what's going to happen in 2019 on a number of
11 fronts, when we really should be elevating the discussion
12 over and above any specific program and taking a deeper
13 dive.
14 So, Sharon and then Alan.
15 COMMISSIONER CARTE: I just wanted to say that
16 although I heard Penny caution about transitioning CHIP, I
17 think you were perhaps thinking all of CHIP into Medicaid,
18 but following up on Kit's line of thought, I could see
19 having enough flexibility at the state level, say, to allow
20 states to draw a new Medicaid eligibility line at 150 and
21 eliminate the stairstep effect, which is helpful for a
22 variety of reasons, not to mention just simplicity and

1 having family households all be in one plan. So, I think
2 being able to set forth a variety of options would be
3 helpful to states, as well.
4 CHAIR ROSENBAUM: Alan.
5 COMMISSIONER WEIL: Although I completely agree
6 with Andy's point that the goal here is health, I do think
7 one of the ways -- one of the criteria for thinking about
8 the next round of policy is what were the goals of CHIP at
9 its enactment, which were to reduce the number of children
10 without health insurance, for which it has been incredibly
11 successful, and we ought to keep reminding ourselves and
12 everyone else of that, as well as to have a highly flexible
13 design so that states would take it up. It was, after all,
14 an optional program, and the choice of entitlement Medicaid
15 expansion or non-entitlement separate plan was a critical
16 part of political compromise.
17 Much of the later dispute had to do with, again
18 not to pick on you, Andy, but coming out of a high-income
19 state, you mentioned that there are lot of kids up at the
20 higher income levels, and there's, of course, political
21 disagreement about whether it's appropriate to subsidize at
22 that level. If you live in a high-cost state, it seems

1 completely appropriate. If you live in a poor state, it's
2 harder to stomach the notion that your federal tax dollars
3 are going to subsidize people with incomes much higher than
4 the median income in your own state, and that's a political
5 decision we don't have to get into.

6 But, I would just say that as we're thinking
7 about this going forward, I would not -- I wouldn't want us
8 to lose sight of the original goals, and part of what we
9 ought to do is measure against whether -- of course, the
10 context has now changed completely. There are exchange
11 subsidies that weren't available back then. The employer
12 market has shifted dramatically.

13 It does seem to me that without telling anyone
14 else what they should do or what their values ought to be,
15 it's important to weigh in on the question of whether
16 certain policy changes that occur in the future will or
17 will not have an effect on the goals of the program as
18 originally enacted.

19 CHAIR ROSENBAUM: [Off microphone.] Toby.

20 COMMISSIONER DOUGLAS: I just want -- I mean, not
21 to disagree -- the goals, I mean, I agree those were the
22 original goals, and as, you know, what we saw, though, is

1 those goals started to get, you know, whether -- a lot of
2 them around the flexibility of CHIP went away over time,
3 from, as I said, from the benefits and eligibility and
4 payment that it became -- there is still the idea of having
5 a separate program and that flexibility, which I think
6 you're right for many states is an important value, and
7 that question, that's where I was more questioning on an
8 analysis of and what does that mean from a consumer
9 experience, having it.
10 But, I think when you measure against the
11 original goals, you have to remember those original goals
12 have changed based on policies that occurred over time that
13 really started to put -- embed into CHIP Medicaid rules.
14 COMMISSIONER LAMPKIN: Yes. Just, I think this
15 goes back to the criteria question and something that -- a
16 comment that's been made by a couple of folks around
17 families whose coverage among different family members is
18 in different places because of the way the program is
19 structured today. Did I understand correctly from an
20 earlier conversation that we don't have good data about
21 where these children's families, other members of these
22 children's families are getting their coverage?

1 CHAIR ROSENBAUM: [Off microphone.] It's the
2 issue of mixed-coverage households. Information on mixed-
3 coverage households is probably still a while away. There
4 may be some studies. Peter, are you aware of any special
5 studies that -- I don't think so. I mean, this is one of
6 the -- I find it personally one of the most crucial
7 unknowns. We have inferred from a number of different
8 types of evidence that take-up rates vary depending on
9 whether it's individual or family coverage. That, we, I
10 think, are relatively secure in knowing.
11 But, this issue of how families cope with
12 multiple -- you know, you could have employer coverage,
13 Medicaid coverage, Medicare coverage, and CHIP all in the
14 same household, depending on the circumstances of
15 individuals, and I don't think we know enough about that.
16 MR. PETERSON: And I'll just add that there are
17 some -- like the National Health Interview Survey has
18 results out that can show some of this, but these are new
19 data, given a new type of coverage, and I think that for
20 the wonks who study this are taking it slow on what to do
21 with those estimates before going too far with it.
22 COMMISSIONER LAMPKIN: So we really don't have a

1 lot of great resources to help us understand this. Over
2 the course of this year where we're having these important
3 discussions, this is just -- okay.
4 CHAIR ROSENBAUM: So we are at time for now. We
5 clearly have an enormous amount of information. We also
6 have an enormous amount of information that we don't have,
7 so that famous saying, we know what we don't know. The
8 most dangerous thing is not exactly knowing what it is we
9 don't know, but we know a lot, and we can identify things
10 that might be good to know that we're not going to have the
11 benefit of in formulating options and recommendations.
12 And obviously, those unknowns will qualify some
13 of the options. They may lead us to add options that we
14 might not leave on the table if we had more information,
15 but I think what is clear to me is that we know an awful
16 lot.
17 Actually, the past year or so, we've spent
18 getting a lot of information up on the table at least about
19 coverage, about the quality of coverage, the scope of
20 coverage, how one type of coverage performs against
21 another, and we know something about -- I think one of the
22 really remarkable things about this slide is that it does

1 provide insight into how states -- I am thinking now not
2 about the federal messaging, but how states, given various
3 tools, have been using those tools. What's the more likely
4 pattern for a state that has chosen to cover at a very high
5 level? There are, I think, some important stories here.
6 So we actually have, I think, more information
7 than we might realize, but a lot to think about and a lot
8 to get ourselves organized about in a hurry.
9 We do have, as we have been doing now for some
10 time, two public comment periods, one this morning and
11 then, of course, one at the end of the day. So do we have
12 public comments at this point?
13 Thank you very much, Joanne and Chris.
14 **### Public Comment**
15 * [No response.]
16 CHAIR ROSENBAUM: Well, seeing no public
17 comments, we are in recess until about 1:30.
18 [Whereupon, at 12:28 p.m., the meeting was
19 recessed, to reconvene at 1:30 p.m., this same day.]
20
21
22

1 AFTERNOON SESSION

2 [1:34 p.m.]

3 CHAIR ROSENBAUM: Okay. So here we are. It's
4 afternoon. We are fueled up, ready to go, and it's time to
5 turn to the session on functional assessment tools for
6 Medicaid long-term services.

7 So, Kristal, take us through it.

8 ### **Functional Assessment Tools for Medicaid Long-**
9 **Term Services and Supports Eligibility and Care**
10 **Planning: Part 2**

11 * MS. VARDAMAN: Great. Thank you. Good
12 afternoon, Commissioners. I'm looking forward to today's
13 continuation in our conversation on functional assessments
14 for long-term services and supports.

15 In October, we reviewed the results of an
16 inventory that NORC conducted for MACPAC with functional
17 assessment tools for LTSS. Today, I am going to have a
18 brief recap of that discussion before going into some of
19 the additional analyses that we conducted as a result of
20 the discussion in the October meeting and with a review of
21 some of the policy questions and talk about next steps.
22 We're thinking about a potential chapter for the June

1 report, and we'll like your direction and feedback on what
2 we might want to highlight, expand upon, or add to in this
3 discussion of functional assessments. And then I'd be
4 coming back to you in March with a draft report.
5 Just in terms of background, a quick recap,
6 functional assessment tools are used to collect information
7 on applicant's health status and needs to determine their
8 functional eligibility for LTSS. It's also often used to
9 form care plans. Given limited federal guidance in this
10 area, there's a lot of variation among states and their
11 approaches and the tools that they use, and that's
12 something that was highlighted by the Commission in its
13 June 2014 report on Medicaid's role in LTSS.
14 In response to the Commission's interest on this
15 topic, we contracted with NORC to compile a comprehensive
16 inventory of tools that states are using for functional
17 assessment, which they did for us in mid-2015.
18 I will highlight some of the key results. NORC
19 identified 124 distinct tools that are in use by states.
20 It's worth noting here that outside the scope of NORC's
21 work was collecting tools that are maybe used by managed
22 care companies in states with managed long-term services

1 and supports. Managed care companies may use those tools
2 to, for example, develop care plans. Given the increased
3 number of states that have MLTSS, that is something that we
4 would like your perspective on how we might discuss that
5 and their role in a chapter.
6 NORC did find that states used an average of
7 three tools each and were using a variety of different
8 approaches, some using separate tools for individuals with
9 physical disabilities compared to the tools they're using
10 for individuals with intellectual or developmental
11 disabilities. However, most states were using homegrown
12 tools that were developed by their staff, contractors, and
13 the input of stakeholders rather than those developed by
14 some independent entity.
15 Looking across the tools, NORC found a large
16 amount of variation, but did find that virtually all states
17 were assessing functional limitations, clinical needs, and
18 behavior and cognitive status in some way, and slightly
19 fewer, but still most tools were also gathering information
20 on the physical environment, psychosocial needs, and other
21 issues.
22 In the discussion, Commissioners raised several

1 questions in October. We've done some follow-up work here
2 and some additional things that are to come to try to flesh
3 out some additional analyses and answer those questions
4 that you had last year.
5 So walking through each one of these in this next
6 session of the presentation, first, looking at some
7 additional inventory results, you asked us to look a little
8 bit deeper at some of the tools and how they might be used,
9 but the states are using the same tool in many instances.
10 And NORC had done some categorizing of tools for us, so we
11 tried to cut the data to try to better understand if there
12 is any consensus around certain tools. And with the
13 exception of a couple tools here, the supports Intensity
14 Scale and Inventory for Client and Agency Planning used for
15 individuals with intellectual or developmental
16 disabilities. There really wasn't a great deal of
17 consensus, and even when we broke down the data, we found
18 that states were really mostly using homegrown tools. And
19 that may be for many reasons, some of which we'll get to a
20 little bit later when we talk about our conversations we
21 had with some states.
22 Another thing that we looked at was comparing

1 assessment items. Some questions came up about, you know,
2 given that most tools are going to be collecting
3 information on something like activities of daily living,
4 how much variation is there and the level of detail they
5 collect. States may collect varying amount of information
6 for many reasons. They're certainly collecting information
7 that's needed to match to their level of care criteria, and
8 so they may have reasons why questions may vary that way.
9 In addition, greater detail might be useful if states are
10 using this information for helping to develop care plans.
11 In your briefing materials, there are a couple of
12 examples that we have provided, one example being bathing,
13 an activity of daily living. You can see that in one
14 example, the state asked questions regarding whether a
15 beneficiary in need of assistance with bathing uses
16 adaptive equipment versus a personal aide. Another state
17 may add an additional layer of information asking for the
18 frequency and duration of assistance required, and then
19 still another state requested information on specific
20 equipment and specific subtasks where assistance was
21 needed.
22 When we talked to some states -- and I'll get to

1 that a little bit more later -- one thing that they did
2 note was that behind some of these assessments training and
3 things that lead into the assessment, being able to
4 categorize beneficiaries, also can incorporate information
5 about what kind of subtask they need help with and what
6 kind of equipment, but some states go the step of making
7 sure all of those details are recorded while others have a
8 higher level of information that they're collecting.
9 So to better understand states' decision-making
10 regarding functional assessment tools and why there's so
11 much variation, we spoke with Medicaid staff in eight
12 states. We tried to select them to have a mixture of
13 states that were using homegrown tools and those that were
14 using independently developed tools, and we also talked to
15 a couple states that were actually currently in the process
16 or recently either selected or created their own assessment
17 tool.
18 There were a number of things that came out of
19 those interviews, and I'll just highlight four themes here
20 today. First, without clear guidance for an existing tool,
21 or federal guidance, or clear advantages for an existing
22 tool, many states said that they developed homegrown tools.

1 Many of the states who have gone through a recent
2 implementation of a tool noted that they had collected
3 information on different states' tools. They had spoken
4 with their peers in different states and tried to
5 understand what the merits were of different tools and
6 developing their own, and that's kind of the approach that
7 they took to gather information.
8 In addition, states' decisions to implement a new
9 assessment tool were often driven by the availability of
10 resources. In a few minutes, we'll talk about a little bit
11 of the Balancing Incentives Program. A number of states
12 that we spoke with who had participated in it noted that it
13 gave them the resources to be able to streamline tools, to
14 move from several to one or two, and that that was critical
15 in giving them the ability to implement new information
16 technology systems to support increased reporting and
17 increased help for program management.
18 Next, we also heard from states that when they
19 are developing their own tools, the ability to customize
20 the tool is very important. So states often noted that
21 stakeholder input was really important to gathering
22 consensus around a particular tool, and that stakeholders

1 may want to address questions or ask questions, and that
2 that was something that was an issue with some of the
3 independently developed tools, there were limitations to
4 how much of the tool they could change. And so some states
5 felt that there wasn't enough room for them to customize.
6 Other states felt like they could work within those
7 parameters, but that was really a divide in terms of
8 whether or not they needed to make their tool or not.
9 And then, finally, certainly there are needs of
10 different populations that may lead to the use of different
11 tools, but another thing that we noticed was that the way
12 states organize how they deliver LTSS services can lead to
13 multiple tools. So the needs of different populations that
14 may require different tools are also reinforced by the fact
15 that some of the waiver programs are administrated by
16 different agencies or different divisions.
17 CMS has undertaken a number of initiatives that
18 are related to functional assessment. We're highlighting
19 two today. First, the Balancing Incentives Program
20 described a little bit in detail in your briefing
21 materials. It requires participating states to, among
22 other requirements, adopt a standardized functional

1 assessment tool if they were not already using one.

2 It requires that certain domains be included, but
3 it didn't require specific questions. Several of the
4 states that we spoke with who participated in the Balancing
5 Incentive Program did note that they added a few questions
6 generally around community integration issues, like
7 employment goals or volunteer goals, because of the BIP
8 requirements. But generally, they felt like either the
9 tools that they were already using were sufficient to meet
10 the BIP requirements or didn't require many more edits to
11 be made.

12 In addition, the Testing Experiences in
13 Functional Tools demonstration is currently ongoing. CMS
14 is pilot-testing Functional Assessment Standardized Items,
15 a question set for use in HCBS settings, and we have had
16 some discussions initially just at the staff level about
17 the progress of that pilot testing, which is ongoing and
18 expected to go on for the next couple of years. And so
19 we're planning to talk to CMS a bit more and try to
20 understand their goals for that program as we continue to
21 flesh out a draft chapter.

22 In terms of policy questions, the first question

1 we have for you here to discuss today is "What is the
2 appropriate federal role in functional assessment for LTSS,
3 specifically if CMS should provide additional guidance?"
4 Given that there was lack of consensus on tools and we did
5 hear from states that they have a variety of strategies in
6 order to evaluate existing tools to help them with their
7 decision-making, is there a place for CMS to do some of
8 that work as well and to provide guidance for states?
9 In addition, there was at least one state that we
10 interviewed that noted that it did not participate in the
11 BIP and would like to streamline some of its tools that
12 it's using, but would require additional resources,
13 particularly in terms of IT infrastructure to do so.
14 The second question we have here is "Should all
15 states be required to use either a standard tool or a
16 limited set of questions? Should there be additional
17 reporting requirements?" This is something which you
18 discussed a bit at the last meeting -- or in the October
19 meeting, and a course requiring that all states use either
20 the same tool or some limited set of questions would allow
21 for some comparisons across state programs, might reduce
22 duplication. However, of course, it also would reduce

1 flexibility to states, and as I noted, some states need
2 resources in order to do some of the data reporting and
3 implement some more sophisticated tools than they currently
4 have.
5 So, with that, I'm hoping to get your feedback
6 on, again, things that we can expand upon, focus on, and
7 the direction of a potential report chapter.
8 Thank you and I look forward to your discussion.
9 CHAIR ROSENBAUM: Thank you so much.
10 So we have asked Brian for his maiden voyage here
11 to do the opening review.
12 COMMISSIONER BURWELL: I can see the old ones
13 just love it, you know.
14 [Laughter.]
15 COMMISSIONER BURWELL: The previous ones as
16 opposed to the newbies.
17 So I'll start with two caveats. One, I am by far
18 not an expert on functional assessment. There are people
19 who dedicate their entire careers to the measurement of
20 functional deficits. I have some people in my group who
21 are far better at it than I am, so I'll do what I can, but
22 there are people who are far more, much greater experts at

1 this than I am.

2 The second caveat, I just want to clear the air

3 that I am in no relationship to the Secretary of HHS, even

4 though we share the same name. There were two lines of

5 Burwells, a Virginia line and a Connecticut line. Her

6 husband, she took his name as the Virginia line, and I'm

7 from the Connecticut line.

8 CHAIR ROSENBAUM: The better line.

9 COMMISSIONER BURWELL: The better line, no doubt.

10 Right.

11 So functional assessment tool, I think it would

12 be good to frame our discussion a little bit, and tolerate

13 me. I'll just do a very simplified overview of how people

14 access LTSS benefits under Medicaid.

15 So all persons who want to access LTSS have to go

16 under functional assessment, which is commonly called the

17 level of care assessment. That's true for institutional

18 care or home- and community-based care. The level of care

19 assessments predate the waver program. They go back

20 forever. A lot of the current level of care criteria are

21 pretty outdated. They are much more a medical model,

22 clinically oriented. So the tools -- and some require

1 physician signatures, et cetera, so you need that level of
2 care assessed to whether you need the level of care
3 provided in nursing home care -- and a nursing home or any
4 other institutions like the ICF/DD or whatever, whatever
5 institution is.
6 And so everyone who receives the waiver, people
7 on the waiver must meet the same level-of-care criteria as
8 someone in an institution. They are supposed to be
9 equivalent populations. So the same tools are used for
10 both waiver populations and institution populations.
11 You know, they can be less or more stringent.
12 Just because you're in a nursing home doesn't mean that you
13 qualify for Medicaid level of care. You can be a private-
14 pay individual in a nursing home, get the Medicare
15 benefits, spend down your assets, and qualify for Medicaid
16 financially, but you may not meet the Medicaid level of
17 care criteria. And you are out of luck. You have to go
18 somewhere else.
19 So that's kind of the initial gateway into
20 Medicaid LTSS benefits. They often have their own set of
21 staff or vendors who conduct those assessments anytime
22 somebody applies, and that is largely what is talked about.

1 Then once somebody is determined eligible, both
2 functionally and financially for long-term care, there is
3 usually a handoff. So, in fee-for-service, it's generally
4 hand off to a local service coordination agency who may
5 manage waiver programs. In managed care, it's a handoff.
6 The person is then asked to choose a plan, and there's a
7 handoff to the plan.
8 So, generally, at that point, there is a second
9 assessment that is done. Sometimes, there is a cross-walk
10 between the initial assessment and the new assessments, but
11 sometimes they're entirely different processes conducted by
12 different people.
13 And the purpose of the second assessment is for
14 care planning purposes, and that second assessment is
15 generally only for HCBS recipients. So everybody in a
16 waiver program is required to have an individualized care
17 plan, and that care plan is developed from this assessment.
18 And that, I would say is more kind of social model. It's
19 more comprehensive. It assesses the recipient's entire
20 service needs, their environment, the level of informal
21 supports, et cetera, and that ends up being developed into
22 a care plan.

1 Now, Kristal is entirely right. Both these sets
2 of tools differ dramatically across states and even within
3 states, and there are many reasons for that. One is that
4 they are different. From the level-of-care side, there are
5 different criteria for different types of institutions.
6 Then that gets translated into different level-of-care
7 criteria for different waiver programs because waiver
8 programs are in lieu of institutional care. Those go back
9 forever. So a DD agency has level-of-care criteria for
10 entrance into DD institutions and DD waivers, and there's
11 different for HIV, for persons with autism, persons with
12 traumatic brain injury, et cetera, so different level-of-
13 care assessments for different levels of institutional
14 care. And then there are obviously different populations,
15 and so assessment tools vary according to -- somebody who
16 has traumatic brain injury requires an entirely different
17 set of assessments than somebody with physical deficits.
18 And other reason tools vary is that the benefits
19 available under HCBS waiver programs vary from waiver to
20 waiver. Since the assessments are care plan-oriented,
21 they're oriented towards assessing whether the person needs
22 the set of benefits that are potentially available to them

1 in a wavier program. For example, a very simple example,
2 some waivers cover home modifications. Some do not. So if
3 it does cover home modifications, then you do an assessment
4 of the home and barriers, et cetera, and that then gets
5 developed into the care plan.
6 Both sets of assessments tend to be ADL based.
7 Certainly, the level-of-care criteria generally are ADL
8 oriented, and the criteria for age of persons, anyways,
9 tend to be fairly similar across states. It's usually two-
10 plus ADLs, and so there are five ADLs: bathing, toileting,
11 eating, mobility, and dressing. And so you need two out of
12 those five deficits to meet nursing home level-of-care
13 criteria.
14 But as Kristal also mentioned, how do you
15 actually measure those items is highly variable, and that's
16 what a lot of people want to see standardized. If you're
17 going to measure a deficit on a certain ADL, it makes sense
18 for everybody to be measuring them kind of the same way.
19 And that's what a lot of the more advanced
20 experts are doing, is developing that, and that's what
21 we're doing in the TEFT demonstration. I also need to say
22 we are the contractor for the TEFT demonstration, so we're

1 actually doing some of this work.

2 I want to bring up the issue of -- and also to go
3 back, in the assessment process for care planning
4 development, as Kristal said, a lot of those forms, those
5 assessments just get -- states sit down, and they draw them
6 up, or whatever. It comes out of their legacy programs or
7 whatever. There are some proprietary tools out there.
8 Companies sell assessment tools, and some states buy them.
9 And in the report, there's a reference to the lack of
10 transparency. And because they're intellectual property,
11 there are kind of limits on the degree to which states that
12 use those proprietary products can talk about them and talk
13 about how they're constructed. Obviously, the people who
14 are selling those tools don't want people stealing their
15 constructs.

16 So there's a little lack of transparency there.
17 All the case managers are out there doing these
18 assessments, so there's not that much -- I mean, people are
19 aware of that, but it's just kind of how the instrument is
20 constructed is not widely shared sometimes.

21 So, secondly, as people know, the states are
22 quickly moving their long-term care systems from

1 traditional fee-for-service models to managed LTSS models.
2 Approximately half the states now have some kind of MLTSS
3 program, and many states only have an MLTSS system, and
4 certainly my personal opinion is that trend is going to
5 continue. States, for a variety of reasons I won't get
6 into, feel that a managed care purchasing model is the way
7 to go with LTSS.

8 So in that environment, the state generally does
9 the initial level of care criteria to determine whether
10 someone's eligible, they could get referred to a plan.
11 Once they're referred to the plan, the plan itself has the
12 service coordinators and sends out people into the home and
13 does the care assessment. So, again, those assessments are
14 often considered proprietary. We're talking about the big
15 national plans. Anthem and United and Molina -- they all
16 have their own proprietary assessment tools.

17 There's also considerable innovation and
18 advancement, so it's not only to develop a care plan, but a
19 number of those companies have risk stratification
20 algorithms that they use when they do assessments. So
21 people may get stratified into different tiers, high-risk,
22 you know, to low-risk. Persons in the high-risk may get

1 different levels of service coordination. For example,
2 they may get more home -- you know, you have to have a
3 certain number of home face-to-face visits per year versus
4 if you're in a low-risk you can have just telephone
5 contacts. Additionally, people in the high-risk categories
6 may have service coordinators with lower caseloads, so, you
7 know, some service coordinators may only have caseloads of
8 50 of high-risk people but then the low-risk get 150, and
9 that's all getting more systematized.
10 And some of the plans are also -- so they tend to
11 be more electronically based and are developing algorithms
12 around care plan development. So you'd have this set of
13 scores, and your assessment, you get this kind of standard.
14 Now, those are always adjustable clinically, but there is
15 standardization.
16 So there is a movement -- there are a number of
17 trends going on, which is states which initially may have
18 developed multiple HCBS waiver programs, some of them have
19 9, 10, 11, 12, 13 different waivers and are wanting to
20 consolidate them into fewer, which means that there would
21 be assessment tools that are more generic across disability
22 types.

1 Also, when states are moving to a managed care
2 model, they often consolidate their waiver programs into a
3 single contract. So there's a consolidation trend going
4 on. There's also a movement from paper-based forms to
5 electronic forms. So that's obviously a big -- you know, a
6 lot of them were just paper assessments the case managers
7 or people kept, you know, in hard-copy files. As states
8 are now moving to more electronically based assessments,
9 that creates an opportunity, obviously, for more
10 centralized information and data systems.
11 And I do think that there are people who would
12 like to see -- well, another trend I forgot to talk about
13 is kind of the electronic exchange of information across
14 providers, which is part of the TEFT program. So in order
15 to exchange data across LTSS providers, it should be in
16 standardized formats, et cetera. So that's another trend
17 that's going on.
18 So what we are saying in this draft report is
19 correct, but I also think there's just a lot of change
20 going on in this area at the current time and a lot of
21 innovation, and it'll be hard to capture that, you know, as
22 a point-in-time thing.

1 You know, we may want to kind of track how this
2 is going and developing, particularly picking up more about
3 kind of what's going on in the managed care environment,
4 although we have this kind of proprietary component of it,
5 I mean, the importance of the assessment process as part of
6 your competitive advantage in the marketplace is a very
7 important part. So that could be increasingly difficult to
8 get good information about as MLTSS becomes more of a
9 competitive marketplace.
10 So I'll stop there.
11 CHAIR ROSENBAUM: Thank you. That was terrific.
12 And I wonder, as we open it up for general discussion -- I
13 mean, I sort of made this little running list of questions,
14 but I wonder, Penny, from your perspective, obviously CMS
15 has been grappling with these issues for -- I have to say,
16 as just an aside, I joined the National Health Law Program
17 while we were still in the final stages of litigating Smith
18 v. O'Halloran, which, of course, was the case that began --
19 it was sort of the alpha case in this area of long-term
20 services and how you figure out the levels of care that are
21 needed. Alan probably remembers coming into Colorado
22 sometime post Smith v. O'Halloran, and it has been this

1 huge evolutionary process, and it sounds like it's, you
2 know, unfolding along with an industry that is also rapidly
3 developing.
4 And so I wonder from the CMS perspective sort of
5 where you all have felt you needed to do some steering,
6 where you decided you needed to sit back and let the skills
7 develop, the industry develop.
8 COMMISSIONER THOMPSON: Thanks. Yeah, I was
9 going to actually -- maybe my role here will be the
10 counterintuitive, be careful of asking for federal
11 standards person.
12 So just in general on that point, this seems to
13 me exactly the place where you want state variation. So
14 there isn't a lot of science. There isn't a lot of
15 information. There are a lot of moving pieces. The
16 programs are changing themselves. Our understanding is
17 changing. There isn't a really good reason at this
18 juncture based on the knowledge that we have, until we have
19 the TEFT process completed, about preferring one thing to
20 another thing. And I think the state officials' comments
21 about the fact that, you know, they want to involve their
22 local folks and their stakeholders is a really important

1 part of value, unless there's a good reason not to do that.
2 And it's sort of like, well, there's really an answer to
3 this, and we know with confidence that there's an answer
4 that's, you know, 90 percent better than the answer that
5 you could come up with if you were doing it locally.
6 So this is a place where I would say allowing
7 some of that evolution of thinking and work at the state
8 level and ensuring that the state stakeholders have the
9 input into the instruments and feel confident about them
10 and feel ready to implement them is a big plus.
11 You know, sometimes states feel compelled to do
12 that kind of local customization when there isn't something
13 that they can take with confidence off the shelf. So if
14 you're a state and you want to be improving or implementing
15 a functional assessment and you've got something that you
16 can turn to and say, oh, this is a standard, this is the
17 standard in the industry, or it's going to be something
18 that you can just pull off, and there's all this enabling
19 technology around it, and we don't have to develop that our
20 own, and we can just bring it into our environment, then
21 you can potentially make an argument to just take it and
22 go. But if you don't have something like that, it's harder

1 to make the argument that, well, let's just take a few
2 other states and see what they did, and then we'll sit our
3 people down and see what they think and come up with
4 something that seems to make sense for us.
5 So, you know, the question being, should CMS be
6 doing more? I feel like CMS is doing the TEFT work as a way
7 to get at understanding what makes a difference or what
8 doesn't make a difference, and we should be watching that
9 and looking for that to continue and make progress.
10 I do think there's a difference in terms of
11 proprietary tools between a functional assessment being
12 used to establish eligibility and a functional assessment
13 being used to do care planning. IP has a place in the
14 latter. I don't think you -- you have to have complete
15 transportation and an audit trail back to why you made an
16 eligibility decision, right? So I think that there is a
17 little bit of a difference as to whether or not you're
18 trying to employ this in the context of your MMIS or ENE
19 systems as part of an assessment process to determine
20 whether Medicaid is going to pay for your care and what
21 kind of care versus your entering a provider or plan
22 arrangement and now they're going to work with you to

1 figure out what the right plan of care is.

2 COMMISSIONER BURWELL: But I want to go back to

3 the level of care tool. I mean, that is not an instrument

4 or a tool that necessarily should be static. I mean, it's

5 not -- it changes with policy. LTSS is changing. I'll

6 just give an example.

7 So the state of Tennessee five years ago had

8 virtually no HCBS system whatsoever, so your only option

9 was a nursing home. So the level of care criteria for a

10 nursing home was pretty broad because people needed a place

11 to go.

12 Well, they enacted the Choices Program that

13 greatly expanded HCBS. They decided a year ago or two

14 years ago they're going to tighten their nursing home

15 criteria. You cannot get into a nursing home now in

16 Tennessee like you used to because now there are other

17 options.

18 So things change because of policy. So trying to

19 say this is the perfect tool and you should use this -- I

20 mean, you could say here's a tool, now you can change the

21 scoring --

22 COMMISSIONER THOMPSON: Apply policy to get --

1 COMMISSIONER BURWELL: -- yeah, you can move it
2 up or down, at this score or that score, you know, that's a
3 possibility.
4 CHAIR ROSENBAUM: So mindful of the time, I have
5 Peter and Toby. And I do have a question for Leanna,
6 actually. Not to put you on the spot, but if I could come
7 back to you, because I think it might be helpful to the
8 discussion.
9 COMMISSIONER SZILAGYI: Just very quickly -- by
10 the way, this is far from my expertise as anything, so take
11 this with a ton of salt. But if we were going to do an
12 experiment across states, I would think what we would want
13 to know is that for the same population, how did this state
14 deal with it or this state deal with it or this state deal
15 with it? And what are the outcomes?
16 So if that is what we would want to know, then I
17 would think that we would want to standardize the first
18 part of what Brian was talking about, which is the
19 eligibility, and to make that the same across states. And
20 then watch what happens across states. So this is sort of
21 -- I'm trying to create -- it's almost like a hypothetical
22 experiment, but that is what we are having in this country

1 with 50 experiments going on, or more than 50 experiments.

2 COMMISSIONER THOMPSON: Well, one is that I do

3 think that's in part what the TEFT demonstration is doing.

4 It is engaging with states as they're looking at

5 populations, at least -- and, Brian, speak to this. I

6 think it is across states, but also in states, so that

7 they're applying their own instruments and then applying

8 some standardized approaches so that there would be some

9 conclusions about what kinds of differences occur both in

10 the state, depending on which kind of instrument and set of

11 questions you're using and what differences occur between

12 states. Is that not correct?

13 COMMISSIONER BURWELL: That's true.

14 COMMISSIONER THOMPSON: So I think that CMS is in

15 the process of exploring that and trying to develop some of

16 those insights, which, I mean, I think, again, that's about

17 developing the underlying science that would tell you that

18 you have an approach that is superior to an approach. And

19 that's what I think at this point we don't have a lot of,

20 is science around which kinds of approaches are more

21 reliable and more valid in measuring what it is they're

22 looking to measure.

1 CHAIR ROSENBAUM: Let's quickly get to Toby and
2 Alan, and then I'd like to [off microphone].
3 COMMISSIONER DOUGLAS: I just wanted to certainly
4 echo some of the comments. I would be very concerned with
5 CMS playing a bigger role in this area. From my
6 experience, you know, in California, for 20, 30 years,
7 we've been trying to work on uniform assessment tools.
8 There's so many different -- and it brings together so many
9 different perspectives and points of views on how to do it
10 where we end up continuing to have a different assessment
11 process.
12 That being said, the evolution with managed care
13 is just totally changing this whole discussion, and we're
14 just at the beginning of it, because I think plans will
15 continue to evolve on their thinking on how to provide the
16 care for these populations. And so an assessment process
17 and trying to standardize it while we're thinking through
18 payment structures and delivery system structures is all
19 changing. It's just not the time. So I think we need to
20 let that whole evolution, as well as the delivery and
21 payment structures, to play out more before we see what the
22 right things and more focus on outcomes and performance.

1 CHAIR ROSENBAUM: But it does suggest -- this
2 discussion also suggests that we may want to watch it on
3 two different levels -- the eligibility question and then
4 the service question -- and they're obviously highly
5 related questions, but the policy intervention may be
6 different depending on whether we're talking threshold
7 eligibility question or the service mix.
8 COMMISSIONER GORTON: And, Sara, I think there's
9 a third level, which is finance, what Toby was talking
10 about. These things are being used to risk-adjust payments
11 for MLTSS, and that's a whole different ball of wax.
12 COMMISSIONER WEIL: I won't repeat but I'll align
13 myself with the comments about the risks of trying to
14 standardize before we know more, and that there is an
15 appropriate federal role but it's not picking one.
16 But to add just another topic which maybe is a
17 little variant on what Peter was raising, there's the tool
18 and then there's how the tool is used. And we know from
19 national data on SSI eligibility, there is huge variability
20 in the rates at which populations make it through what is
21 supposed to be a federal standard. So it just seems to me
22 as we're thinking about this analytically, we can't just

1 stop with looking at tools. We have to then go to the next
2 level to see whether they are used the same way in
3 different places.
4 CHAIR ROSENBAUM: All right. And, Leanna, my
5 question for you actually goes to Brian's observation about
6 transparency. And, of course, the chapter talks about the
7 fact that there may be limited transparency. Brian makes
8 the point that there are many reasons, business reasons,
9 why tools may be or may not be transparent.
10 I would assume that if you are -- and I don't
11 know whether you've had this experience personally. Most
12 families with children with disabilities do at one point or
13 another. You're either dealing with an eligibility issue
14 or a service issue. You know, the child lost eligibility,
15 which doesn't happen all that often, but the mix of
16 services changes.
17 Has that happened to you? And when it has, have
18 you had any difficulty getting the assessment -- full
19 access to the assessment tools that were used, the results,
20 the nature of the findings? It would be great to talk a
21 little bit about sort of the flip side of this, which is
22 are families able to get access to the results of these

1 assessments?

2 COMMISSIONER GEORGE: In general, I have been

3 allowed to get access to results. I just contact my care

4 coordinator, my daughter's care coordinator, and just

5 request whatever documentation I need. As far as different

6 assessments, the only ones she's had since she came home

7 from a residential facility has been the SIS evaluation,

8 and that really doesn't do very well in helping with goal

9 planning, which I think is probably almost even more

10 important than figuring out what level of support is needed

11 so that we can start working toward those goals and see

12 progress being made.

13 CHAIR ROSENBAUM: So it seems to me -- and I know

14 we are hard on a time stop for the next panel. It sounds

15 to me as if we need to do some more work on developing the

16 material, that we're not -- it doesn't sound like we're in

17 a place where we're ready to make recommendations yet. I

18 think it might be good to try and summarize where the

19 Commission would like some more information. I mean, one

20 of them is, of course, this distinction between tools being

21 used to assess eligibility, and it may be the same tool for

22 services, and yet they're used differently. They may play

1 different roles at different times. This question of sort
2 of an evolving industry and how the evolution of the
3 industry may be changing thinking about where regulatory
4 intervention would be appropriate at this point, the
5 uncertainty about the performance of any particular tool in
6 relation to so many different criteria that may change
7 depending on whether we're talking about the efficiency of
8 services or the outcome for families or what have you.
9 So maybe one of the benefits we could provide at
10 this point based on Brian's excellent summary and all the
11 observations at this point is sort of a state of -- a state
12 of the field from a number of different perspectives, from
13 the perspective of where states are, where the evolving
14 industry is, where the research is around the tools
15 themselves, where the thinking is about, you know, the
16 impact of different tools for different purposes, and maybe
17 sort of trying to lay out more of a -- instead of using our
18 chapter to sort of drive toward a recommendation at this
19 point, use the chapter to try and capture for Congress what
20 the state of long-term services and supports evaluation and
21 service delivery looks like at this point in community
22 settings and, you know, the grappling with the tools and

1 suggesting potentially further areas for research.

2 COMMISSIONER COHEN: It might be worth it -- I

3 mean, for new Commissioners but also for old ones whose

4 memories are short -- just to do a little bit more of a

5 rehash of what the Long-Term Care Commission did.

6 CHAIR ROSENBAUM: Yeah.

7 COMMISSIONER COHEN: Either a summary or

8 something rather -- deeper than just what was their end

9 result recommendation, but, you know, sort of a little bit

10 more --

11 CHAIR ROSENBAUM: And why they came where they

12 did, yes. And I think also Brian's lead-in, which was very

13 nice, to just give a little bit more context, which be

14 great. And then I think we will have sort of captured a

15 moment -- you know, a moment in time and pointing out all

16 of what's evolving in this moment in time. That would be,

17 I think, really a contribution.

18 COMMISSIONER BURWELL: I'd like to comment on one

19 more trend --

20 CHAIR ROSENBAUM: Yes.

21 COMMISSIONER BURWELL: -- that I think is

22 impacting this issue, is the trend towards integration of

1 services with the duals, and I see LTSS moving much towards
2 a population management approach. And then with that, all
3 the discussions around the social determinants of health,
4 because one thing that's going on with managed care is that
5 a lot more people are being touched, and you get the
6 managed care companies coming back going, we go into these
7 people's homes and we're supposed to do a care plan and
8 there's no food in the refrigerator, you know, and there's
9 no roof or whatever. So, the whole social determinants of
10 health movement is impacting this issue.
11 CHAIR ROSENBAUM: [Off microphone.] All right.
12 Well, thank you very much, Kristal.
13 So, now, we are -- this is the problem with
14 MACPAC. You could spend [inaudible]. But, Anna is going
15 to present new and very interesting data for us on
16 providers who serve Medicaid patients.
17 **### Providers Servicing Medicaid Patients**
18 * MS. SOMMERS: Thank you, Sara.
19 Low participation by physicians has been raised
20 as a barrier to access for Medicaid beneficiaries. State
21 officials, health plans, and physicians have documented the
22 existence of this problem, but there is little data to

1 quantify participation with sufficient detail to support
2 decision making by policymakers.
3 Much of what we know about provider participation
4 has been drawn from national surveys of physicians. The
5 most widely known is the National Ambulatory Medical Care
6 Survey. Three limitations of the NAMCS are that
7 participation is self-reported by physicians, only office-
8 based physicians are sampled, and it cannot produce
9 specialty-specific measures at the state level.
10 So, we are left with several gaps in federal data
11 that hinder monitoring of the Medicaid provider workforce.
12 We do not have data to examine participation levels from
13 other angles, such as the number of Medicaid patients seen
14 by participating physicians. We cannot observe variation
15 in participation levels across specialties or the impact of
16 other practitioners who could meet patient needs. Finally,
17 measures of the distribution of supply within states are
18 needed to monitor shortage areas within states.
19 Conducting provider-level analysis at the state
20 level is now possible using the 2012 Medicaid Statistical
21 Information System due to mandated use of the National
22 Provider Identifier, NPI, on claims. Providers that bill

1 third parties are assigned a unique NPI through the
2 National Plan and Provider Enumeration System, or NPPES.
3 This system allows us to describe the workforce serving
4 Medicaid patients using the 2012 MSIS.
5 Staff conducted an extensive investigation into
6 the completeness of the NPI fields in the 2012 MSIS and
7 validated other provider-level information in MSIS with
8 codes in the NPPES data warehouse. These details are
9 included in the methods appendix of your memo.
10 Our data set contains all individual
11 practitioners who listed their own NPI as the servicing
12 provider on at least one Medicaid claim or encounter in the
13 2012 MSIS. We defined all of these individuals as
14 participating in Medicaid, which is a broad definition. We
15 excluded institutional providers.
16 We constructed five measures of the Medicaid
17 physician supply and participation by state and physician
18 specialty. These measures are described on page 32 of your
19 memo. We were able to produce state-level and specialty-
20 specific measures for 34 states.
21 We also share some data on other health care
22 professionals, such as advance practice nurse

1 practitioners. These data should be viewed with caution,
2 though. Claims data are known to undercount practitioners
3 who do not bill directly for their services. Many
4 practitioners who are directly supervised by a physician or
5 another clinician do not have their own NPI, or even if
6 they do, they may record another clinician's NPI on claims.
7 Before I get into the specifics, there are
8 several key findings to highlight, and again, these results
9 should be treated as preliminary.
10 First, participation rates we estimate from MSIS
11 are generally higher than other published estimates based
12 on the NAMCS physician survey data. According to the 2011
13 NAMCS, 69 percent of physicians reported accepting new
14 Medicaid patients. Our national rate is closer to 84
15 percent. While our rates are very close to those from
16 NAMCS in some states, our data show significantly higher
17 rates in many states.
18 At least two factors may contribute to this
19 difference. The NAMCS includes only office-based
20 physicians, while MSIS also includes hospital-based
21 physicians. Although empirical evidence of participation
22 levels by hospital-based physicians is limited, we do know

1 that outpatient departments serve Medicaid patients
2 disproportionately. Last spring, we reported nearly 45
3 percent of all enrollees received services in outpatient
4 departments, not including emergency rooms.
5 Another factor is that NAMCS participation is
6 based on physician reports of acceptance of new Medicaid
7 patients. Our definition is based on actual claims for an
8 entire year, and we include any physician who saw even one
9 patient.
10 Second, measures of physician supply and
11 participation vary widely across states within each
12 specialty and within each state between specialties.
13 Third, a significant share of physicians within
14 all the specialties we examined served five or fewer
15 patients, though estimates again varied widely.
16 Finally, in states with moderate Medicaid managed
17 care penetration, the majority of physicians served both
18 managed care and fee-for-service patients.
19 Our presentation today focuses on state variation
20 within measures for a few individual specialties:
21 Pediatric surgical specialists, psychiatrists, and
22 obstetrician/gynecologists. We also review other provider

1 types that we capture in our data. Measures for other
2 specialties are described in your memo and appendix tables.
3 Pediatric surgical specialists are some of the
4 rarest specialties in the U.S. The pediatric subspecialty
5 areas we could identify were pediatric surgery and
6 orthopedic surgery. We counted a total of 1,221 pediatric
7 surgeons serving Medicaid enrollees. The underlying table
8 for this is on page nine of your memo.
9 The first two bullets show measures of physician
10 supply relative to the enrolled population. We found that
11 of the 34 states for which we could produce estimates, 20
12 states had a supply ratio of less than one surgeon per
13 10,000 children. Looked at a different way, the number of
14 enrolled children per surgeon ranged from 2,200 to over
15 49,000 children per surgeon. And the median patient
16 caseload of participating surgeons ranged from one patient
17 to 398 Medicaid patients.
18 Psychiatrists are essential to the behavioral
19 mental health workforce because they have prescribing
20 authority. Here, we show two measures of participation
21 levels based on the number of patients seen by each
22 participating psychiatrist.

1 Across states, the percentage of psychiatrists
2 serving five or fewer Medicaid patients ranged from nine to
3 61 percent of participating psychiatrists. The median
4 patient caseload of psychiatrists ranged from two to 125
5 Medicaid patients.
6 We also, though, identified many psychologists,
7 counselors, clinical social workers, therapists, and
8 analysts serving Medicaid enrollees. In many states, these
9 professionals exceeded the supply of psychiatrists. And
10 again, our data will undercount these professionals.
11 There's a recognized shortage of
12 obstetrician/gynecologists in the U.S. In 2010, nearly 50
13 percent of the U.S. counties had no OB/GYN providing direct
14 patient care. Across states, we found the number of
15 enrolled women per participating OB/GYN ranged from 95 to
16 1,061 women. Between eight and 53 percent of participating
17 OB/GYNs served five or fewer Medicaid patients.
18 On the other hand, many advanced practice nurse
19 midwives, nurse practitioners, and physician assistants
20 specializing in women's health serve Medicaid enrollees,
21 too. In at least 16 states, these practitioners exceeded
22 the supply of OB/GYNs. And again, our data will undercount

1 these professionals.

2 The Medicaid workforce, as we know, is far
3 broader than physicians. Here, we highlight a little data
4 on other practitioners and health care professionals, but
5 we can only provide a lower bound estimate of the numbers
6 of other professionals serving Medicaid patients. This
7 lower bound is about 400,000 health care professionals.
8 The most common provider types we found are listed on the
9 slide. This number includes professionals that we could
10 count in the 17 states we did not produce state measures
11 for because we know we have incomplete provider data.

12 Finally, we conducted a brief analysis of the
13 overlap in participation by physicians in Medicaid fee-for-
14 service and managed care programs by state. We classified
15 providers as participating in comprehensive managed care if
16 they had any encounter data submissions and participating
17 in fee-for-service if they had any fee-for-service claims.

18 As an initial cut, we looked at participation by
19 general internal medicine and surgical specialists. We
20 focused on 16 states with 30 to 90 percent of the
21 population in comprehensive managed care where we would
22 expect a sizeable physician network in fee-for-service and

1 in managed care. In almost all of these states, over 60
2 percent of physicians participated in both fee-for-service
3 and managed care.
4 That concludes our very brief summary of results.
5 As for next steps, we could refine these participation
6 measures. For instance, we found that a significant share
7 of physicians serving any given state's Medicaid population
8 reported that their main business practice location was in
9 a different state. We would like to learn more about these
10 physicians.
11 We could identify specialist physicians who
12 practice in primary care by looking at their claims data.
13 We could also identify the non-pediatric specialists who
14 serve children based on claims and encounter data.
15 This data set will also support a range of other
16 analyses about providers. For instance, we could identify
17 enrollees with a specific condition and examine their
18 contact with certain providers. We can also investigate our
19 capacity to measure provider access in sub-state areas.
20 So, that concludes my presentation. We look
21 forward to your thoughts on refining and improving these
22 measures as well as how measures could be used to further

1 investigate access to care for Medicaid beneficiaries.

2 CHAIR ROSENBAUM: Thank you very much.

3 I have actually two technical questions. I think

4 maybe I'm posing them to Penny. I'm not sure.

5 The first is, under the proposed Medicaid managed

6 care rule, if I recall, the changes being made under

7 program integrity are that you can no longer be in a

8 managed care network if you're not, in fact, registered as

9 a Medicaid participating provider, right?

10 COMMISSIONER THOMPSON: Directly with the state,

11 that's right.

12 CHAIR ROSENBAUM: Yes. So, absolutely, you could

13 be a provider who registers with the state but only sees

14 children in managed care, I suppose --

15 COMMISSIONER THOMPSON: But you still wouldn't

16 have fee-for-service claims. You would just --

17 CHAIR ROSENBAUM: You're right. Exactly.

18 COMMISSIONER THOMPSON: -- through the screening

19 process --

20 CHAIR ROSENBAUM: But you would always --

21 COMMISSIONER THOMPSON: -- directly with the

22 state to authorize you to bill --

1 CHAIR ROSENBAUM: Yes.

2 COMMISSIONER THOMPSON: -- and serve Medicaid and

3 a managed care --

4 CHAIR ROSENBAUM: Yes, but you would always --

5 COMMISSIONER GORTON: You might have a handful,

6 right? You could take care of a kid you thought was in

7 managed care and it turned out that they're eligible --

8 COMMISSIONER THOMPSON: No, I'm just saying it

9 just is a matter of requirement whether you would or

10 wouldn't, but --

11 COMMISSIONER GORTON: Right, but all I'm saying

12 is you could be thinking your practice was 100 percent

13 managed care, and you saw a kid and you billed and you

14 found out that the date of eligibility was, in fact, two

15 days after the date of service, and so that one gets paid

16 as fee-for-service.

17 CHAIR ROSENBAUM: Right. I'm less concerned

18 about the payment methodology. I just want to be sure we

19 are clear that, assuming finalization of the Medicaid rule,

20 it is not possible for a physician to be in a Medicaid

21 managed care system, or will not be possible, without being

22 directly registered with the state, and I was just

1 uncertain as to whether the early work assumes -- this
2 early work assumes that you could have, essentially, two
3 groups of physicians.
4 The group of physicians has to be a Medicaid
5 participating physician. Whether the physician then thinks
6 for some reason he or she is only seeing managed care
7 patients -- and, in fact, it never works out that way for
8 all kinds of reasons. There are all kinds of services that
9 aren't inside a contract, that are after the date of
10 enrollment, disenrollment, or whatever. But, as we sort of
11 -- if we want to shape more research here, there are sort
12 of these multiple layers of questions we're asking. But,
13 the relationship between the physician and the state will
14 always now be there. That's all. You can't just have it
15 with the MCO. It has to be with the state.
16 EXECUTIVE DIRECTOR SCHWARTZ: And this, since
17 this measures just contacts --
18 CHAIR ROSENBAUM: Right.
19 EXECUTIVE DIRECTOR SCHWARTZ: -- it's -- you
20 know, we could do more to look at the group that has
21 significant overlap as opposed to the ones that are seeing
22 a handful of patients for the situation that Kit raises.

1 CHAIR ROSENBAUM: Right. So, I think the
2 questions for us here are what are -- what value might this
3 data set bring to us? What more might we like to know?
4 What kinds of refining questions might we want to have
5 MACPAC staff pose? I mean, what we have in front of us,
6 which is a wonderful thing that we don't typically get to
7 see, is possibly a new source of information that we're
8 looking at in the early stage to get a sort of a feel as to
9 what's there and how might we want staff to proceed.
10 COMMISSIONER DOUGLAS: First, a technical
11 question. Where -- how does it capture physicians in
12 FQHCs? Are they --?
13 CHAIR ROSENBAUM: [Off microphone.] Yeah, I
14 wondered about that.
15 COMMISSIONER DOUGLAS: Where are they falling
16 into this?
17 CHAIR ROSENBAUM: [Off microphone.] -- hospital
18 outpatient clinics. Wherever the institution is the billing
19 provider.
20 COMMISSIONER DOUGLAS: Were they not part of
21 this, or --
22 MS. SOMMERS: Yes. They should be part of it.

1 COMMISSIONER DOUGLAS: Okay.
2 MS. SOMMERS: We're taking the NPI data from the
3 service, where they should be reporting the servicing
4 provider, which is an individual, for the most part --
5 COMMISSIONER DOUGLAS: Yeah. I just thought with
6 FQHCs, I just don't -- I can't remember, again, if they're
7 actually the provider or if the FQHC is the --
8 CHAIR ROSENBAUM: [Off microphone.]
9 COMMISSIONER DOUGLAS: -- the NPI. So, I just
10 didn't know how it's captured on this.
11 MS. SOMMERS: We weren't able -- in our
12 investigation of the NPI fields, we were able to look at
13 the completeness of the NPIs and the extent to which
14 individual practitioners reported by the type of service
15 and program, and one of those is FQHCs.
16 COMMISSIONER DOUGLAS: Okay.
17 MS. SOMMERS: And, so, we were seeing individual
18 practitioners listed as NPIs in those fields at a very high
19 rate.
20 COMMISSIONER DOUGLAS: So, one question I'd have
21 is how, if there's a value of slicing, of looking at FQHCs,
22 just the role they play. Again, if it wasn't in California

1 -- you know, the FQHCs were a huge component of the access,
2 and when we were doing payment reductions, the reason we
3 were able to do it is because there were FQHCs that were
4 within the system. So, just how much of the total, how
5 does that vary by state, and that would be important.
6 Overall, I think it's really good. The one
7 question I have is just kind of the framing of some of the
8 tables, and the question it's framed around, that so many
9 providers, in general, are serving the Medicaid population.
10 But once you slice away that five percent, I mean the ones
11 that -- you know, it's just glass half full or empty. And
12 these are showing it to me more from the half full, and the
13 question is, have you looked at the percent -- if you said,
14 okay, only those who serve more than five, these percents
15 would be very different. And, so, you know, how do we want
16 to characterize -- to be as balanced as possible, I wonder
17 if we need a show above.
18 CHAIR ROSENBAUM: But, what does it mean to
19 participate?
20 COMMISSIONER DOUGLAS: Yeah.
21 CHAIR ROSENBAUM: I mean, we understand
22 technically what it means to participate, but I think

1 you're asking the question of where do we want to set
2 certain thresholds, and in terms of, you know, the depth or
3 the scope of the --
4 COMMISSIONER DOUGLAS: Yeah, and how is the data
5 being used --
6 CHAIR ROSENBAUM: Yeah.
7 COMMISSIONER DOUGLAS: -- and appropriately
8 understood from both perspectives.
9 CHAIR ROSENBAUM: I have Alan, Sheldon --
10 EXECUTIVE DIRECTOR SCHWARTZ: I would just sort
11 of add to that is that we -- these tables have a lot of
12 columns in them, and part of that was to show you some of
13 the things we could do. We, obviously, we have the inverse
14 of the fewer than five. We have those, you know, with huge
15 numbers, and we could show an entire distribution if we get
16 rid of some of the other columns in there. So, there's a
17 lot more capacity to do that. This was really to sort of
18 show you -- and I think this is a helpful comment for us to
19 think about. If we get rid of some of those other columns,
20 we could zero in on sort of, on the distribution.
21 CHAIR ROSENBAUM: Okay. I have Alan, Sheldon,
22 Sharon.

1 COMMISSIONER WEIL: Yeah. So, I'll just start by
2 saying this is an area where we desperately need
3 information, and the rhetoric around this and the anecdotes
4 around access have driven the discussion for so long that
5 having a new data source that could potentially answer some
6 questions is huge.
7 But, I -- and this is a little where Toby was --
8 my first reaction is the next steps are not about
9 additional analysis. They're really about validation, not
10 just in the way you've approached identifying the measures,
11 but in acknowledging that you're coming up with different
12 numbers than the ones that are out there from a different
13 data source, and then asking the questions that, you know,
14 your and my former colleagues have spent many years on,
15 which is how do these correlate with measures of --
16 patient-reported measures of unmet need or barriers to
17 care, so that instead of picking an arbitrary, well, those
18 who take -- see fewer than five should be in or out or we
19 should count these, to actually have an evidence-based
20 threshold that suggests that when the saturation rate, the
21 take-up rate, exceeds X percent of those who are above
22 such-and-such a level, it actually correlates with higher

1 levels of access.

2 So, I guess my broad comment is, because this is
3 so new, I'm much more interested in figuring out what it
4 means than looking at it different ways, because until we
5 know what it means, looking at it different ways won't tell
6 us what it means in different ways. It'll just be looking
7 at it in different ways. So, that's the general comment.

8 CHAIR ROSENBAUM: Sheldon.

9 COMMISSIONER RETCHIN: Yeah. I think I remember
10 this discussion and why we got into this, and like Alan, I
11 do think that this is an incredibly important area and
12 congratulate Anna for taking it on.

13 That said, like Alan, I think validation of the
14 data is a very important next effort. Now, that said, one
15 thing to do is just take one area, one provider. Since
16 there's so much surrounding it, I might suggest behavioral
17 health, but I don't know.

18 I was just looking just in terms of face
19 validity. There are either a lot of crazy people in South
20 Dakota and Wyoming, or it's just where psychiatrists like
21 to go to ski or get away. But as I was looking at that,
22 what I thought you could do would be to catalog these by

1 states, just say, "Okay. These data are right, even though
2 they're only participation. It's not new patients," which,
3 by the way, to me, if I were to try to judge that, the
4 participation rate that I would want to be getting at if I
5 had to err would be those who accept new patients rather
6 than just claims.
7 And I don't know, by the way, on NAMCS. Do they
8 have those state-level data?
9 MS. SOMMERS: Their sample sizes support an
10 overall participation rate in Medicaid at the state level
11 for all physicians, and in some cases, primary care, but we
12 can't look at individual specialties.
13 COMMISSIONER RETCHIN: So one idea even there
14 would be to correlate the two -- I don't know if you did
15 that -- just in terms of low participation rate, medium,
16 and high, even, to know whether this has validity.
17 And then, like Alan said, you could also look at
18 access issues or unmet needs certainly be state and region,
19 right? Because these are very interesting data.
20 The other comment I would have would be --
21 although it's interesting and I am looking to Peter on this
22 -- some of the rare specialties, like pediatric surgeons,

1 raise a whole different issue in terms of access problems,
2 and a low provisions of services, I don't know how many is
3 enough on pediatric surgeons. I know there's literature
4 out there, but then you have to ask even then.
5 To me, just looking at the fundamental,
6 behavioral health and general medicine, given the expansion
7 now in the Medicaid states, I think that's a big unknown in
8 terms of primary care, adult primary care. I just would
9 focus on those areas that are so important.
10 CHAIR ROSENBAUM: Sharon and then Norma.
11 COMMISSIONER CARTE: Well, like the others, I
12 have to note, this is really exciting stuff, Anna. It will
13 be great when it can be more rounded out. I think it would
14 be a great value to the Commission in helping us finally
15 put more oomph into the access part of our title.
16 CHAIR ROSENBAUM: Put the A in access.
17 COMMISSIONER CARTE: Put the A in access,
18 exactly.
19 Early on, though, you mentioned under state
20 participation rates that there are 17 states that were
21 unable to produce data, and I see a certain amount of the
22 data is coming to you through MSIS, and pretty soon, we

1 will have T-MSIS. Would you be able to characterize -- I
2 mean, not like next month on T-MSIS, but it's coming. So
3 would you be able to characterize, like, in a year or two
4 if we would be able to see a full 50-state --
5 MS. SOMMERS: What I can say is that most of the
6 states that we had to exclude were excluded because of
7 incomplete or poor quality managed care encounter
8 submissions. There were a few, I think six states, we had
9 to exclude because of the incompleteness of NPIs. We would
10 expect that completeness rate to go up pretty quickly. It
11 went up about 5 percent just between 2011 and 2012.
12 I cannot answer the question about T-MSIS.
13 CHAIR ROSENBAUM: Norma and then Sheldon.
14 COMMISSIONER ROGERS: Well done, Anna. I just
15 wanted to kind of make a comment along -- I think it was
16 Sheldon who said this. You know, it would be really good
17 if we could see the regional areas, like is it rural or is
18 it -- what do the rural communities look like? I'm kind of
19 curious because I know that in many of the -- South Texas,
20 for instance, we have no psychiatrists and no
21 pediatricians, period, and we have a high rate of consumers
22 there. So I'm curious as to, are they all in Dallas,

1 Texas; or San Antonio -- or where are they? Because
2 they're not in other areas. Is that possible to get?
3 MS. SOMMERS: There are two limitations I'll just
4 briefly mention. One is that there is some question as to
5 how reliable the practice business location is that's
6 registered in the NPPES with the NPI, but it is required
7 for billing, so it is considered to be fairly up to date.
8 But that is only one of their locations that they've chosen
9 as their business location, so they can have multiple
10 locations, and we wouldn't know what those other locations
11 are.
12 CHAIR ROSENBAUM: Yeah. For example, with health
13 centers, you have on average seven locations, and
14 typically, they would report their main office as the
15 location.
16 I actually wanted to ask this question. It's
17 sort of a variation on Norma's question, which is, is there
18 a way to not only put participation in perspective, meaning
19 are you a significant participation person or not? And I
20 do remember work that's about 40 years old now from, I
21 think, Mathematica, where they developed gradients of
22 participation. We used to cite it all the time in

1 litigation. I mean, the old Mathematica studies, I don't
2 know what data. I forget what data they used, but they had
3 gradients, and how they arrived at those gradients, I can't
4 remember.
5 But the other question I have is whether there's
6 a way also to frame the participation in relation to both
7 the location -- urban, rural -- the population density and
8 the degree of poverty, so that we know whether our higher
9 participation rates are in -- I mean, it could work in one
10 of two ways. It could be that the higher the poverty area,
11 obviously if you're a clinic or a physician practicing
12 there, I don't know who else you're going to see, but on
13 the other hand, it could be paradoxically that wealthier
14 areas with fewer Medicaid beneficiaries in relation to the
15 population are also places where certain kinds of providers
16 may be more willing to see patients because they're not
17 concerned that suddenly their practice will be overwhelmed.
18 And I think pediatrics is a particularly interesting
19 example of this.
20 As you struggle with just trying to get through
21 these data themselves, the relationships between population
22 characteristics and where do we get significant

1 participation, I think would be very useful.

2 Sheldon.

3 COMMISSIONER RETCHIN: I know there is a

4 sentiment not to do further analyses, but if I could just

5 ask one on this, maybe two, can you sort the states by

6 Medicaid expansion to look at the general -- we would

7 certainly expect participation rate, and you might even

8 take off the bottom 5 percent.

9 That brings me to another issue on the

10 participation rate. I assume that's a continuous variable

11 since you have all of the claims, right?

12 MS. SOMMERS: Yeah. We can see the full

13 distribution of the patient caseloads.

14 COMMISSIONER RETCHIN: So, if you took it down to

15 the countervailing analysis by NAMCS to 70 percent, what

16 would that look like in terms of claims? If you assumed --

17 I know it's a big job, but if you assumed that those

18 physicians were accepting new patients, I just wondered

19 what their caseload would look like at 70 percent, the same

20 --

21 MS. SOMMERS: Could you clarify your question?

22 What do you mean? Seventy percent of what?

1 COMMISSIONER RETCHIN: You've got in this
2 analysis, overall, an 84 percent participation rate,
3 recognizing that includes somebody who saw a Medicaid
4 patient accidentally. They just wandered into the office.
5 [Laughter.]
6 COMMISSIONER RETCHIN: If you took that down to
7 the 69.4 participation rate in the NAMCS, which included
8 only those who accepted new patients, what does that
9 caseload look like? What does that number look like? Is
10 it 50? Is it 40 and depending on the state?
11 MS. SOMMERS: Yeah. We actually did some of
12 those runs. If you take out the physicians who have five
13 or fewer patients, then what does the median, the
14 distribution of the patient caseload?
15 COMMISSIONER RETCHIN: Right, right.
16 MS. SOMMERS: We haven't presented or really
17 looked at it that much. Didn't have time.
18 CHAIR ROSENBAUM: Well, thank you very much,
19 Anna. This is great, and we're now at break. We'll take
20 about 10 minutes and reconvene at three.
21 [Recess.]
22 CHAIR ROSENBAUM: All right. We are going to

1 take our seats and reconvene.

2 EXECUTIVE DIRECTOR SCHWARTZ: I just want to let
3 people know that a ring was found, a ladies' ring, in the
4 ladies' room, that our folks out front have. So if you are
5 missing a ring with something that looks like a diamond but
6 maybe not be a diamond --

7 [Laughter.]

8 CHAIR ROSENBAUM: But it's very pretty.

9 EXECUTIVE DIRECTOR SCHWARTZ: But it's very
10 pretty. Check your fingers, check your pockets, and talk
11 to Eileen or Annie out front.

12 CHAIR ROSENBAUM: So we are up to now Tab 7, and
13 Mary Ellen Stahlman is going to walk us through a
14 historical review of proposals to reform Medicaid. This,
15 of course, is part of our work in relation to responding to
16 congressional requests for information on past Medicaid
17 reform proposals. So take it away, Mary Ellen.

18 **### Historical Review of Proposals to Reform Medicaid**

19 * MS. STAHLMAN: Thanks very much. The purpose of
20 this presentation is to provide Commissioners with an
21 overview of past Medicaid reform proposals focusing on key
22 approaches to reform underlying the proposals from

1 presidents' budgets, Medicaid commission, governors'
2 associations, and policy research organizations or think
3 tanks.
4 The presentation will provide some context for
5 the work -- why we did it -- and a few notes about
6 methodology, how we did it. It will review key Medicaid
7 reform approaches, highlighting examples of major
8 approaches, provide Commissioners with some staff thoughts
9 and observations on the themes we identified across the
10 proposals, and some final thoughts on the challenges of
11 major Medicaid reforms going forward. Staff look forward to
12 Commissioners' additional observations on past reform
13 efforts and how this work might inform MACPAC's work going
14 forward. Clearly, some of you have had front-row seats in
15 developing some of these proposals or implementing them at
16 both the state and the federal level, so the staff are
17 particularly interested in your discussion about what you
18 see going forward and what you think the themes are across
19 prior efforts.
20 A little bit of context. Clearly, almost since
21 their enactment, Medicaid and CHIP have been the subject of
22 reform debate by Congress and the policy community.

1 Proposals have been offered to change Medicaid's
2 eligibility, its financing, benefits, program management,
3 and spending trajectory. Reform proposals come from across
4 the political spectrum and reflect the policy concerns of
5 the day, the perspectives of their authors, and the
6 likelihood of enactment.
7 In 2015, in the spring of 2015, Members of
8 Congress, including members from the authorizing committees
9 for Medicaid and CHIP, from both the House and the Senate,
10 requested that MACPAC evaluate past reform proposals from
11 presidents' budgets, blue ribbon policy commissions, think
12 tanks, governors' associations, and Medicaid commissions.
13 So this work was done in direct response to that request,
14 and that letter is in your briefing material just behind
15 the staff memo. An understanding of the objectives and
16 outcomes of past reform proposals informs the Commission's
17 analysis of policy options under consideration today. The
18 past is prologue, as they say.
19 To respond to the congressional inquiry, MACPAC
20 undertook a literature review of comprehensive reform
21 proposals offered by presidents, policy Commission,
22 Governors, and think tanks. Given the sheer number of

1 proposals offered over the years, we tried to put some
2 parameters around what we would focus our review on. So we
3 did focus on proposals that include a substantial reform
4 related to Medicaid, CHIP, or Medicare-Medicaid dually
5 eligibles. There are clearly many other proposals that are
6 much narrower in scope. There are many of them. Many of
7 them are worthy to look at, but we did try to narrow the
8 scope a little bit so we wouldn't still be reviewing
9 proposals right now.
10 We also focused on proposals that make changes in
11 Medicaid or CHIP at the federal level rather than at the
12 state level. Clearly, the states every day are grappling
13 with Medicaid reform proposals of their own, and there are
14 many, many of them. But we did limit our focus to federal
15 proposals. And we also limited our review to proposals
16 that include a well-defined specific set of
17 recommendations. So there's a lot of work out there that's
18 very descriptive in nature or describes one type of
19 approach for reform or another, and we really tried to
20 focus our effort on those proposals that made an actual
21 recommendation.
22 In terms of the time frame we captured, we tried

1 to be as inclusive as possible while trying to limit our
2 review to proposals that might be still relevant today. So
3 we included proposals all the way back to 1980 from the
4 presidents' budgets. A few interesting points on that
5 score. Some of the MACPAC staff were not born in 1980,
6 which was horrifying to me as I was starting to work with
7 the junior staff.
8 [Laughter.]
9 MS. STAHLMAN: Another interesting tidbit is that
10 you'll notice that there are links to most of the source
11 materials that we used in that big long table that's in
12 your material, but fewer links for the presidents' budgets.
13 Some of the source material we used for that was in hard
14 copy in the basement of somebody that some of you might
15 consider a colleague, and so you wouldn't believe what
16 lengths MACPAC staff will go to respond to a congressional
17 request. So some of that material was a little hard to find
18 back to 1980. We did want to capture, however, some of the
19 proposals that the Reagan administration had regarding
20 Medicaid, particularly on FMAP, so we were happy to do
21 that.
22 In terms of the blue ribbon policy and Medicaid

1 commissions, we went back to 1990. We really wanted to
2 capture the Pepper Commission -- many of you remember the
3 Pepper Commission as being a very comprehensive reform
4 proposal, and since there are fewer of those bigger blue
5 ribbon or congressional policy commissions, we wanted to
6 make sure that we could at least capture that.
7 For the governors' associations and the think
8 tanks, we went back to 1997. We thought 1997 might be a
9 good cutoff point. Clearly, there have been a lot of major
10 expansions since 1997 and the enactment of CHIP, so we
11 thought if we could gather those proposals, that would be a
12 good stopping point and those proposals would be most
13 relevant.
14 So the proposals are summarized in your briefing
15 material. It's 50 or 55 pages of material. So the quiz is
16 later.
17 I would say it's a working draft. You'll see
18 that there's lots of work to be done. We didn't want to
19 wait until the next Commission meeting to bring this
20 material to you, but it is a little hot off the press. So
21 before it is delivered to Congress, we'll make sure that
22 your comments are included. It doesn't have to be today.

1 You can let us know if you see anything that you want
2 updated. We're also cleaning those documents, particularly
3 the section where we make notes about what has been enacted
4 or not. So, anyway, some of the Commissioners will
5 recognize their own names on some of those proposals.
6 Most of the proposals we reviewed seek to achieve
7 multiple objectives. For example, a lot of the proposals
8 that would grant states additional flexibility are coupled
9 with reduced spending. Some proposals are more
10 comprehensive than others. The Pepper Commission, for
11 example, a very comprehensive proposal; President Clinton's
12 Health Security Act also very comprehensive. Others sort of
13 limit the reform to one aspect of the program, some of the
14 coverage expansions, for example, or the Long-Term Care
15 Commission in 2013.
16 As staff reviewed the many proposals offered over
17 the years, we identified several key approaches to reform,
18 and most proposals fall under one or more of them. The key
19 approaches we identified -- and you may have others --
20 include changes to Medicaid's financing structure or
21 methodology, expansions to coverage or eligibility,
22 delivery and payment system reform, targeted spending

1 reductions, promoting market dynamics, and increasing state
2 flexibility.
3 Many groups have proposed changes to Medicaid's
4 financing structure or methodology. The very next session
5 today will focus on some of those approaches in much more
6 detail, so I won't say much. However, just a few words.
7 Under block grants, as I think most of you know,
8 states are provided a lump sum to use toward Medicaid
9 spending. Most of the proposals on block grants also are
10 coupled with proposals that would grant states a lot more
11 flexibility than they currently have so that they can
12 manage the funding under the block grant a little bit
13 easier. The Cato Institute has explored block grants and
14 is one of the organizations that have done that in recent
15 years.
16 Per capita caps involve a cap on Federal spending
17 on a per enrollee basis. So under this approach, the
18 federal government does limit the money that it gives to
19 states, but it does so on a per person basis. Unlike block
20 grants, a per capita cap would allow total federal spending
21 for the program to rise with any increase in enrollment.
22 So, for example, during a recession or an economic

1 downturn, enrollment swells a little bit. A per capita cap
2 may allow more funding to the states.
3 Proposals that include some type of per capita
4 cap arrangement have been offered by Democratic and
5 Republican Presidents; policy commissions including the
6 National Commission on Fiscal Responsibility and Reform in
7 2000, and some people refer to that as the Simpson-Bowles
8 Commission.
9 There have also been proposals that involve a
10 swap, usually of program benefits. Under a swap the
11 program is divided into parts, and the federal government
12 is responsible for financing and managing some portion of
13 the program, and the states are responsible for financing
14 and managing another portion of the program. A good
15 example of that that's pretty recent is the Urban Institute
16 in 2011 that recommended that the federal government take
17 over Medicaid spending and management of acute-care
18 benefits for adults and children and the states would take
19 a much bigger role for long-term services and supports.
20 The Bipartisan Policy Center's Debt Reduction
21 Task Force in 2010 also had a proposal around swaps where
22 individual states would negotiate with the federal

1 government about which types of benefits they would like to
2 swap -- which sounds complicated to me, but that's what
3 they came up with.

4 There have been many changes proposed to the
5 federal-state matching rate. There have been proposals to
6 reduce the match rate. President Reagan very early on,
7 particularly the administrative match, proposed to lower
8 that match. President Clinton proposed increasing the
9 match for DC. George W. Bush proposed increasing the match
10 for managed care to encourage more managed care. President
11 Obama proposed temporarily increasing the match during a
12 recession. There have also been proposals around blending
13 the match rate, the different match rates within Medicaid.
14 President Obama and the Bipartisan Policy Center have
15 proposals in that regard.

16 There has also been a proposal around a scaled
17 match, which is a higher federal percentage for lower-
18 income people and a lower federal match for higher-income
19 people.

20 Lots of proposals around expanding coverage or
21 eligibility. Many, many proposals in this regard,
22 particularly before the enactment of the ACA. The ACA is

1 the most recent and best example of that. However, prior
2 to that, George H.W. Bush proposed expanding Medicaid to
3 additional groups, including pregnant women and children.
4 The Robert Wood Johnson Foundation's Covering America
5 Project in both 2001 and 2003 recommended expanding
6 Medicaid or CHIP to higher-income levels. And the
7 Commonwealth Fund Task Force on the Future of Health
8 Insurance in 2000 recommended and discussed buy-ins to
9 Medicaid or CHIP for additional families or small
10 businesses.
11 Proposals to reform Medicaid delivery or payment
12 systems have been offered by many different stakeholders
13 over the years. Organizations including the Brookings
14 Institution's Bending the Curve, Commonwealth Fund's
15 Commission on a High Performance Health System have
16 suggested alternative payment approaches, including
17 bundling, episode-based care, pay for performance,
18 competitive bidding, and payment for medical homes.
19 Many proposals from an array of sources proposed
20 increasing coordination between Medicare and Medicaid
21 enrollees: the Bipartisan Policy Center in 2013, the NGA
22 has a very long record of proposals in this area, and, of

1 course, President Obama has done a lot of work in this area
2 as well and proposed that through his budgets.
3 In terms of long-term services and supports, the
4 Pepper Commission back in 1990 recommended significant
5 proposals in terms of long-term services and supports. A
6 congressionally mandated commission on long-term care in
7 2013 also had many proposals in this regard. The Bush
8 administration had many initiatives included in their
9 budgets: Money Follows the Individual Rebalancing
10 Demonstration, the New Freedom Initiative for persons with
11 disabilities, and the Partnership for Long-Term Care, which
12 would have supported the purchase of private long-term care
13 policies.
14 In terms of targeted spending reductions,
15 targeted spending reductions are the backbone of most
16 presidents' budget proposals, but they're also proposed by
17 many organizations, including the Bipartisan Policy Center
18 over the years.
19 While these types of proposals are not really
20 comprehensive reform proposals, particularly with regard to
21 the presidents' budgets, when you see them as a group -- so
22 President Reagan's budget proposals, President Bush's

1 budget proposals -- you get a sense of what their policy
2 direction is, and you get a sense of what the policy
3 concerns of the day are. So we thought they were important
4 to be included for that reason. Some of the smaller
5 proposals that have to do with -- well, not so small,
6 really -- program integrity, a lot of the drug payment
7 tweaks from the Obama administration, very important for
8 them.
9 In terms of promoting market dynamics, many
10 proposals seek to use market forces to achieve savings and
11 program efficiencies. We saw proposals regarding premium
12 support and vouchers under which the federal government
13 would provide a contribution toward the cost of a premium
14 for private sector coverage. In recent years, the Cato
15 Institute and the American Enterprise Institute have both
16 explored premium support and vouchers.
17 Competitive bidding is another type of proposal
18 that seeks to promote market dynamics. The Brookings
19 Institution in 2009, Center for American Progress in 2011,
20 and the American Enterprise Institute in 2014 are just a
21 few of the examples of that.
22 In terms of increasing state flexibility, I have

1 to say almost every proposal that is comprehensive in
2 nature proposes much more state flexibility in one area or
3 another, particularly around waivers and program
4 management. The National Governors' Association again has
5 a very long track record proposing much more state
6 flexibility to manage the program and to make other changes
7 to the program.

8 The HHS Medicaid Commission in 2006 also has a
9 long list of increasing state flexibilities. President
10 Bush had a number of state flexibilities to promote managed
11 care, and George W. Bush had budget proposals particularly
12 that encouraged use of waivers -- some of you will recall
13 the HIFA waivers, Money Follows the Individual,
14 demonstrations around children in residential psychiatric
15 centers. So the proposals around state flexibility are
16 probably the most numerous.

17 So that's just sort of a little taste test of
18 some of the proposals that we reviewed, and clearly, you
19 can tell from your briefing material there are many of
20 them.

21 Some initial staff observations and takeaways --
22 and, again, we'll be interested to hear what your

1 conversation is given how close some of you are to some of
2 these proposals.
3 First, reform objectives reflect the policy
4 concerns of the day. Prior to the enactment of the ACA in
5 particular, there were lots of proposals around expanding
6 coverage to the uninsured. At other times there have been
7 proposals that are really focused on deficit reduction,
8 concerns about the budget. There have been other times
9 assistance to the states was a priority and more
10 flexibility, particularly during economic downturns,
11 program integrity, and more recently, paying for value. So
12 reform objectives, what you see being discussed reflects
13 what the policy concerns of the day are.
14 I would also say that, despite some many
15 differing objectives, there are a few common threads. We
16 saw lots of proposals around fiscal discipline, program
17 integrity, state flexibility, and per capita caps, although
18 I will note on per capita caps the devil is always in the
19 detail in those kinds of proposals. What it's used for and
20 how much money is in the system matters a lot, but we did
21 see a thread over the years, over the decades, and across
22 parties on per capita caps.

1 We would also note that coverage expansions have
2 advanced over the years. The ACA is clearly the most
3 notable, but there have been many incremental expansions
4 over the years, particularly for children. At the same
5 time, there has been less movement, I would say, on major
6 financing reforms, and financing reforms are a tough nut to
7 crack. Changing the financing creates winners and losers
8 across states, and you saw in an earlier presentation today
9 what the CHIP program looks like and what Medicaid looks
10 like, and state variation is unbelievable in terms of their
11 programs, as you well know. And so changing the financing
12 mechanisms in Medicaid is not an easy reform. So a lot of
13 discussion about financing reform, less movement.
14 There have been calls, as I mentioned, for state
15 flexibility for many quarters, consistently around
16 benefits, around eligibility, program management
17 especially, and the waiver process always.
18 There has been a recent focus on value-driven
19 approaches to cost control, particularly in the last
20 several years. And there has been much talk over the years
21 on building on CHIP, either buy-in proposals to build on
22 CHIP or to expand CHIP to other populations. More

1 recently, there has been talk about CHIP-like financing for
2 Medicaid, meaning some sort of capped allotment that could
3 be used for Medicaid, and some more flexibility around the
4 benefit package, more similar to CHIP.
5 One more observation that the staff had is that
6 long-term services and supports is sometimes not addressed
7 in these comprehensive proposals. While there are many,
8 many notable exceptions, including the Pepper Commission,
9 the 2013 Commission on Long-Term Care, some of the swap
10 proposals, President George W. Bush, a lot of long-term
11 services and supports proposals across the years, some of
12 the proposals just say, "And the states will deal with
13 long-term care." States will define what needs to happen
14 there and what kind of reforms are most appropriate for
15 that state.
16 So achieving major Medicaid and CHIP reforms can
17 be quite challenging. Program variation across states
18 creates winners and losers, always making a very
19 comprehensive reform more difficult. Diverse enrollee
20 needs can make reforms more complex. Clearly, Medicaid
21 covers children, covers well children, it covers children
22 with special health care needs, adults, persons with

1 disabilities, Medicare beneficiaries. Reforming a program
2 that covers such a diverse group of people and their needs
3 and making major changes to it is a big task.
4 Sometimes competing incentives of the state and
5 federal financing mechanism can create tension between the
6 states and can create differences in what the outcome
7 should be, especially where financing is concerned. And,
8 finally, while many proposals call for more Medicare and
9 Medicaid coordination, I don't have to tell this group that
10 coordination across two programs can be quite a challenging
11 endeavor. One is much more federally focused, one is much
12 more state focused, and they have different payment
13 methodologies. And for many reasons, that can be a
14 challenge.
15 So, in terms of next steps, I hope that you will
16 all offer us your words of wisdom on what we could see
17 across these proposals, what themes come out to you, what
18 we should emphasize or not emphasize, and we'll be
19 delivering this material in some form to our requesters on
20 the Hill as soon as we clean up that very long table.
21 So I'll be happy to answer any questions.
22 CHAIR ROSENBAUM: Thanks. Thanks, Mary Ellen.

1 For those of you who don't spend every day of
2 your life or big chunks of it on legislative policy, I
3 cannot overemphasize what a monumental task this is, not
4 only because of the sheer volume of Medicaid reform
5 proposals over five decades, but because there are so many
6 different ways to think about Medicaid reform proposals, as
7 Mary Ellen has elucidated.

8 And there's one level of work here that I think
9 is the immediate response to the requesters' questions to
10 us, but I also think that we would be doing actually a
11 great service to Medicaid policy discourse if we thought
12 about taking all of this work and actually -- and I'm not
13 the technology person -- but thinking about how to build it
14 out through MACPAC to allow a carefully indexed and
15 accessible search of at least the concepts because, in
16 fact, gathering this all in one place, I don't think has
17 ever attempted.

18 MS. STAHLMAN: Well, some of it was in somebody's
19 basement.

20 CHAIR ROSENBAUM: Yes, yes. But literally
21 producing an opus, even if you look at the tremendous
22 histories of Medicaid, I am sitting here thinking about

1 Judy Moore's history of Medicaid that she did with David
2 Smith. Actually, twice now she's done it, and they're
3 fantastic histories. But they deal with high points in the
4 history, not this kind of effort. So there are both the
5 near-term needs to be responsive to the requesters, but
6 then there is the longer-term need I think to do something
7 that actually is a tremendous contribution.
8 So I think we need some discussion about just at
9 the near-term level, what the big themes are as Mary Ellen
10 has suggested that really need to be pulled out, what the
11 big concepts are that you want to be sure are built in so
12 that the requesters can see the proposals, and which kinds
13 of proposals are always linked -- in other words, you never
14 see X without also seeing Y and Z -- to give people a
15 flavor for sort of how you bundle certain kinds of
16 legislative proposals, also the context for certain
17 proposals.
18
19 So why don't we open it up for some general
20 discussion? Alan.
21 COMMISSIONER WEIL: You might imagine I have some
22 thoughts about this.

1 [Laughter.]

2 COMMISSIONER WEIL: I think I showed up twice on
3 your bibliography.

4 I would echo the scale of the undertaking and how
5 valuable it is.

6 EXECUTIVE DIRECTOR SCHWARTZ: A special issue of
7 "Health Affairs" dedicated --

8 COMMISSIONER WEIL: Just on Medicaid reform
9 proposals.

10 This is hard because my views on this subject are
11 not a secret, and I think it's critical that in this, as an
12 entity, we try to not get too swayed by anyone, so feel
13 free to push me back.

14 I have a few big reactions. One is how you
15 categorize these seems really important, and I worry that
16 because this topic has always been so divisive that if we
17 use the categorizations that the proponents and opponents
18 have used historically, we play into the notion that
19 they're Republican or Democrat or left or right or
20 expand/contract kinds of proposals. And that may be true,
21 but there's a lot of gray.

22 And so I was struggling to think about how to try

1 to break down instead of emphasize. That just feels to me
2 like a positive step.
3 The role of context is also really key. I mean,
4 one of the things you have in here that I forgot I had
5 written until I saw it in here, context really matters.
6 Some of these proposals, for example, if they predate the
7 ACA, you might propose things that when there weren't -- I
8 mean, one of the ones you have in there that I wrote, there
9 were no exchanges, so the question is "If you give people a
10 tax credit, where should they go?" Well, maybe they should
11 go to Medicaid. Well, now they would go to an exchange. I
12 almost think you could, like, take that one off your list
13 because the whole point was to create a place to use a
14 credit, and there is one. So I don't know what to think
15 about that, but I do think the context is important.
16 Sorry. I don't want to filibuster. Let me try a
17 few things here.
18 I think it's important to think about changes in
19 the federal-state financial relationship as distinct from
20 the federal-state administrative relationship. I think a
21 lot of the ones that you call financing models are really
22 about the federal-state, right? A cap, a block, this or

1 that. They're not. So the state role here seems critical.
2 And a lot of the flexibility proposals are about changing
3 administrative relationship.
4 There are targeted changes, as you know. There
5 are targeted changes in eligibility and coverage, and there
6 are targeted changes in how we deliver care. It seems to
7 me, again, some of them are expansionary. Some of them
8 might save money. Some of them might cost money. If
9 you're categorizing, rather than talk about coverage
10 expansion, I'd talk about changes in who and what and
11 changes in how to try to break down some of those.
12 And now we get to my somewhat more pointed -- I
13 think the use of the term "markets" is a real political
14 term. The fact is states procure managed care plans
15 competitively. That's a market. I think what you're
16 calling markets are really proposals for enrollees to play
17 a bigger role in making financially relevant determinations
18 about their coverage. So, to me, market just becomes this
19 push button, and if we're doing a categorization, I'd be
20 more precise.
21 There is no question that there are a lot of
22 proposals to give states more flexibility, but again, I

1 find that term not helpful. It's flexibility to do what?
2 So, if it's flexibility to change eligibility, then it's an
3 eligibility proposal. If it's flexibility to change how
4 you deliver care, it's a delivery proposal. If it's
5 flexibility to spend less money on something or to get out
6 from under a rating provisions -- I realize that the
7 proponents of these call them "flexibility proposals," but
8 I think if you're trying to help policymakers understand
9 what the proposals are, we need to stick to things like
10 financing, eligibility, benefits, delivery system and the
11 like, or you get too many cross-cutting.
12 And then there is this whole category when you
13 talk about Medicare/Medicaid, but I think there's this
14 whole category of sort of relationships to other programs,
15 which is I think a growing area. So a lot of the
16 flexibility, for example, of proposals were about taking
17 savings from one program and letting you apply them
18 elsewhere. We got into that with the duals, but it's not
19 just Medicare/Medicaid issues.
20 I hope those are helpful. It's kind of random,
21 but those are my issues.
22 MS. STAHLMAN: No, that's very helpful. This is

1 exactly what we'd like to hear.

2 CHAIR ROSENBAUM: More? Yes, Toby.

3 COMMISSIONER DOUGLAS: As I thought, again, just
4 thinking back, having all congruence of information, it's
5 wonderful. Great, great work.

6 MS. STAHLMAN: Aren't you glad we didn't include
7 the states?

8 [Laughter.]

9 COMMISSIONER DOUGLAS: So, on the challenges and
10 thinking forward, I think one area that I think is just a
11 huge challenge is the underlying way states are financing
12 the program and how to change as you look at proposals,
13 given the reliance in many states of inter-governmental
14 transfers and provider taxes, how reforms impact the
15 different financing, and that gets a little bit into the
16 next section, but to the extent we're looking at any types
17 of changes on the financing.

18 And the other one, maybe it's just understood,
19 but I think the big challenge of any of this is just how it
20 impacts the underpinnings of Medicaid and the entitlement
21 and the protection for the population.

22 CHAIR ROSENBAUM: I think I just want to note

1 that I had noted this issue as well, and I think here, you
2 see the link between Toby and Alan. And I think,
3 therefore, in developing this federal-state financing
4 relationship, just the fundamental thing to convey to the
5 requesters is that it's altering both sides, proposals that
6 alter one side or the other or both, so what is an
7 allowable federal expenditure, is there an upper limit on
8 federal expenditures, if so, how the upper limit is
9 expressed, and then also whether there would be revisions
10 in what sources of revenue states can use to make their
11 outlays.

12 One of the things that I think is a chance for us
13 to clean up terminology is you often see sort of sloppy
14 talking, like state match. That's now how Medicaid works.
15 The state spends money, and the federal government
16 contributes, and so if states' authority over sources of
17 expenditures is altered so that certain sources of spending
18 are no longer allowed as sources of spending, the federal
19 government, no matter what the federal financing system is,
20 will not contribute.

21 And I think that it's really important as we
22 explain this to Congress to move away from the sort of more

1 colloquial language that tends to get used around Medicaid
2 and be extremely precise here because these are legislative
3 proposals, and every word in the statute is incredibly
4 meaningful.
5 COMMISSIONER THOMPSON: I'm not sure if it's
6 going to be possible because I think a lot of these were
7 policy proposals, and they never got, like, legislative
8 language. So sometimes it's hard to convert them to a
9 comparison to what would it really look like as up against
10 the statute today because it was never written to compare
11 to the statute or insert new language in the statute, so
12 you're making some assumptions.
13 First of all, I think this is a really good
14 discussion. I had some of the same comments that Alan had
15 about the language and also about characterizing certain
16 proposals as financing proposals when they have big impacts
17 on eligibility or the status of an entitlement, for
18 example.
19 So I do think to the extent that we can be just
20 more precise about the Medicaid program today is composed
21 of these parts -- it's financing, it's administration, it's
22 eligibility, it's benefits, et cetera -- and that this is

1 the status of what it looks like today, and this is what
2 would happen if you took some of these different kinds of
3 proposals and how that might look differently.
4 So the more I think it can get de-constructed to
5 those very specific domains and dimensions, the more
6 helpful it is to really understand what's being proposed
7 and to get away from, as Alan said, some of the labeling,
8 which tends to propose values that most people would link
9 arms on, but in fact, that the facts or the details really
10 are where people start to diverge.
11 COMMISSIONER BURWELL: Question. Have we had
12 follow-up conversations with the requesters around this
13 particular since April 2015?
14 MS. STAHLMAN: No. They are aware that we are
15 doing it. They know that it's under way, but we haven't
16 had any significant conversation with them.
17 COMMISSIONER BURWELL: Do we have a deadline?
18 MS. STAHLMAN: We don't have a deadline.
19 COMMISSIONER BURWELL: I just think it would be
20 useful to have -- I don't know. I'm a consultant. So, you
21 know, one problem when you're a consultant is your customer
22 asks you to do something. Then you do it, and then you

1 give it to them, and they go, "Well, that's not what I
2 wanted." CMS does that sometimes.
3 EXECUTIVE DIRECTOR SCHWARTZ: We would never do
4 that.
5 [Laughter.]
6 COMMISSIONER BURWELL: Just given our previous
7 conversations, I would just want to make sure that whatever
8 we give them, it will be positively responded to, even if
9 it's not something that we -- the other thing, I'm a
10 newbie, so I don't know. I'm much more, like, do we give
11 them what we think we should give them? Do we seek more --?
12 CHAIR ROSENBAUM: I completely share your
13 thought. I had the same thought as it was going through my
14 mind. I'm not even sure that anybody fully appreciated the
15 significance of what they're asking for, just in terms of
16 the work and what it takes to do a review of this kind,
17 particularly when you have tried, as you have, to be as
18 thorough, actual legislative proposals, outlines of
19 proposals, private proposals. And so I would recommend on
20 this one myself -- I think I'm in the same place as Brian -
21 - that before we go the next step -- we certainly start to
22 capture everything that's coming out now, but you may want

1 to sit down with the requesters and give them an interim
2 briefing on just the sheer volume of what you found, your
3 preliminary thought about how you're going to organize the
4 material for them, and just get a sense of whether you're
5 sort of on track, because this is truly a seminal
6 contribution.

7 And it also is a contribution that requires
8 tremendous choices and precision, and so doing some interim
9 work with the requesters might be a very good idea here
10 before producing the final product.

11 Any other comments on this unbelievable
12 presentation? We've really had a couple of incredible
13 things. Andy?

14 COMMISSIONER COHEN: So I want to agree with
15 Alan's point about the importance of language, and I'm
16 afraid what I'm going to suggest may sound like it's the
17 opposite. And maybe this is like the cross-tab to what
18 Sara has suggested, complex database, searchable,
19 interactive database on all this stuff.

20 But one concern that I have -- and none of these
21 proposals has a piece that is a stand-alone. Everything
22 that was designed to address one problem has implications

1 in other areas and has pieces that are linked. But I am
2 concerned about time has passed, and things have changed.
3 And past is prolog and important, and yet we are in a
4 different environment now than we were in 1997 or 1990 or
5 1980 or even 2005 on a number of dimensions and in a number
6 of issues that really drove a lot of these proposals.
7 I mean, the growth and health spending looks a
8 lot different right now than it did 10 years ago. The
9 availability of other forms of subsidized insurance --
10 there's so many big changes.
11 So what I was throwing out for a reaction, but
12 it's sort of whether or not it's possible to maybe do some
13 cross-categorizing around maybe the issues that the
14 proposals were attempting to address in a way, and again,
15 it's hard to do that in a neutral kind of a way, but in
16 some ways to sort of way to make it clearer where there is
17 a tax credit to use in the Medicaid program, kind of a
18 proposal to make clear what's kind of overtaken by events
19 at least of today, what might be relevant tomorrow, but
20 what might not be today under our current policy.
21 So I'm not sure the way to do is it that way, but
22 I do think somehow or another, we have to sort of like not

1 sort of categorize these as a block of, like, today
2 proposals that you could analyze today, but ones that --
3 and you made the point, but somehow in our sort of
4 categorization, I think we somehow have to highlight those
5 that are just in some ways either literally not relevant,
6 like they just could never sort of work today, or ones that
7 really were designed to address a problem that is not
8 necessarily the problems that are commonly accepted as the
9 major issues of today.
10 CHAIR ROSENBAUM: Anne has a comment.
11 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I just want
12 to follow up on that, Andy, because I think the issue you
13 raise is a really good one, and partly in the interest of
14 helping Mary Ellen, who had no idea when she volunteered to
15 do this what she was getting into, but also because the
16 request that we have is multifaceted. And so some of the
17 things that you raise seem to me very appropriate for
18 Commission discussion but maybe don't have to be satisfied
19 in this particular product, and it might be better in this
20 product to be a little bit more agnostic and descriptive.
21 And then when we get into some of the other bullets in that
22 letter, financing reforms which would reduce federal and/or

1 state outlays on the program, which is both a technique and
2 a goal together, options to provide states with flexibility
3 to manage and design, to enhance efficiency, reduce cost,
4 and improve health care. When we take on some of those
5 items -- and I think the next session is sort of the
6 beginning of that -- to be able for the Commission to both
7 comment on the diagnosis of the problem and the design of a
8 solution to address that diagnosis.
9 So I think actually your comment makes a good
10 segue into the next section, and I think just sort of in
11 the interest of getting this thing done, I'm already
12 thinking that we need a little bit help from our Excel
13 gurus over here to help us tag and code some of these
14 proposals to sort them, which I think would be helpful.
15 COMMISSIONER COHEN: Right, a binary choice to
16 make.
17 CHAIR ROSENBAUM: There is an immediate need here
18 to answer some very specific questions from the requesters,
19 and that's why we need to think near term. And then there
20 is the higher level analysis that should flow from this
21 that we can come back to that actually begins to develop
22 bigger context, because I think it's incredibly useful to

1 remind people where this program has been over 50 years.

2 COMMISSIONER THOMPSON: So just so I understand,
3 Anne, what you're suggesting, are you suggesting that the
4 raw information be deconstructed and tagged and inserted
5 into a searchable database without that much additional
6 framing or categorization and --

7 EXECUTIVE DIRECTOR SCHWARTZ: I think what it's -
8 -

9 COMMISSIONER THOMPSON: -- it's sort of a raw --
10 here's a raw dataset, and in the meantime, our analysis
11 continues and we're continuing to place this?

12 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I think we
13 might do that for ourselves to search it, but what I would
14 imagine us transmitting -- and obviously, it's a point well
15 taken to check in with the requesters, but maybe to take
16 those tables and think a little bit about how the documents
17 are sorted within the tables and to take a look at the memo
18 that was written for you and whether there's a different
19 kind of characterization for a cover memo for it because --

20 COMMISSIONER THOMPSON: Yeah.

21 EXECUTIVE DIRECTOR SCHWARTZ: -- a congressional
22 audience, no matter how well meaning, it's a bunch of

1 executive readers, and so we need to have something short
2 and to the point of which then if they want to dive in.
3 COMMISSIONER THOMPSON: We have a backup
4 document.
5 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. And then,
6 you know, all the issues that Andy raised, I think are
7 absolutely perfectly appropriate for further discussion as
8 the Commission starts to look at more in depth at some of
9 these ideas, which are perennial ideas, some of which don't
10 go to places for certain reasons, but also they continue to
11 have legs and continue to have appeal, so we will see them
12 again.
13 COMMISSIONER THOMPSON: But, in any event, our
14 characterization of the proposals would be something that
15 we would take a hard look at in terms of --
16 EXECUTIVE DIRECTOR SCHWARTZ: Yes, yes.
17 COMMISSIONER THOMPSON: Okay.
18 CHAIR ROSENBAUM: Thank you very much, Mary
19 Ellen.
20 And now the twin presentation, certainly related
21 to what we had just been talking about, is Moira, who will
22 discuss addressing growth in federal Medicaid spending and

1 possible financing alternatives.

2

3 ### Addressing Growth in Federal Medicaid Spending:

4 **Selected Financing Alternatives**

5 * MS. FORBES: Thank you, Sara.

6 So, as Mary Ellen previewed, yes, we'll be

7 discussing in more detail some of the models that have been

8 suggested to change the federal financing approach, and I

9 will say these presentations are related to each other. My

10 heart was sinking a little bit during this last discussion

11 because my slides are riddled with language that you have

12 raised some very appropriate concerns with, so please bear

13 with me. I'm not going to try and sort of police my use of

14 the word "financing" on the fly here. I will read my

15 notes. But, I certainly take your point, and as we go back

16 and take the results of this discussion and turn it into

17 products for our requestors, we will absolutely be very

18 careful and precise about how we characterize things. So,

19 apologies in advance.

20 This builds on presentations that we started last

21 fall, that April and Jim and I have presented in response

22 to these letters from the Hill. We've provided information

1 on the size and cost of the program, on past and projected
2 rates of growth, and the policy levers available to states
3 and the federal government to help bring down the rate of
4 spending.

5 This session addresses another area of
6 Congressional interest and provides more information on
7 specific financing proposals.

8 We'll provide an overview of the current Medicaid
9 financing structure just to level set a little, and then
10 we'll discuss four specific models that have been
11 introduced in Congress, that have been a specific interest
12 of our requestors, or that have been discussed in previous
13 MACPAC meetings.

14 The discussion today is going to be at a very
15 high level. We anticipate bringing you more detailed
16 analysis of design and implementation issues, including the
17 effects of various models on beneficiaries, providers,
18 states, and spending, at future meetings. So, after I walk
19 through each of the models, there will be time for you to
20 discuss what types of analyses you think would be helpful
21 for staff to provide at future meetings.

22 So, a quick overview of the current financing

1 model. State Medicaid programs are entitled to federal
2 reimbursement for a share of Medicaid spending. As state
3 spending increases, so does federal spending, and
4 theoretically, the total amount of potential spending is
5 unlimited.
6 Most state Medicaid spending, about 95 percent,
7 is for health care services provided to enrollees. States
8 also spend Medicaid funds for performing administrative
9 tasks such as determining eligibility, paying claims, that
10 sort of thing.
11 The federal share of the 95 percent of spending
12 that's for health services is determined by each state's
13 federal medical assistance percentage, or FMAP. There's a
14 formula in statute for calculating the FMAP each year. The
15 formula provides higher matching rates to states that have
16 lower per capita incomes relative to national average, and
17 vice-versa, to account for states' differing abilities to
18 fund Medicaid from their own revenues.
19 FMAPs can and generally do change annually a
20 little bit. The changes are usually small, but a difference
21 of even one percentage point can be, you know, tens of
22 millions of dollars difference in the amount of federal

1 funds coming into a state.

2 So, as I mentioned, a key feature of this current
3 Medicaid financing system is that it provides open-ended
4 amounts of federal matching funds to states depending on
5 what states spend. The federal contribution to Medicaid is
6 potentially unlimited, but the federal government has very
7 little direct control over how much to spend on Medicaid.

8 From a state perspective, this open-ended federal
9 match approach allows states to exercise the considerable
10 discretion that the statute provides them in terms of
11 deciding who to cover, what to cover, how much to pay, and
12 so on. States do have to comply with any new federal
13 requirements to cover new groups, new services, new
14 administrative activities, and states do have to come up
15 with state share when there are new requirements imposed on
16 them.

17 States also find that Medicaid enrollment tends
18 to go up during recessions when, at the same time, they
19 have slower economic activity, which can make it more
20 difficult for them to raise their share of Medicaid
21 spending.

22 From the federal perspective, one concern of the

1 current approach is that states have an incentive to
2 increase program spending and to Medicaid-ize health
3 programs where possible in order to draw down Medicaid
4 funds, federal funds.
5 There's also a moral hazard concern. Because the
6 federal government picks up at least 50 percent of the cost
7 of health services, states may have less incentive to be
8 efficient in their spending.
9 Finally, because Medicaid is an entitlement
10 program, to receive federal matching funds, states must
11 agree to operate their programs in compliance with federal
12 rules. These rules can be waived in some, but not all,
13 cases -- a constraint on state flexibility.
14 So, various alternatives have been proposed to
15 address concerns with the current open-ended financing
16 model, and the ones we're going to talk about today focus a
17 lot on the concern that the federal government has little
18 ability to constrain the rate of spending growth, as well
19 as the concern that current program rules do not allow
20 states to implement certain program reforms that would
21 allow them to constrain the rate of spending growth.
22 These policy options include block grants, capped

1 allotments, per capita caps, and shared savings. Each of
2 these alternatives has policy trade-offs, particularly
3 compared to the open-ended FMAP approach used now, and
4 we'll discuss that a little more in the next few slides.
5 It's also worth noting that, I think as came up
6 during the last discussion, a lot of these proposals are
7 very conceptual, and as Mary Ellen said, the devil is in
8 the details. It's difficult for us to really quantify or
9 anticipate all of the potential effects when little is
10 known about how these would really operate in practice.
11 So, first, block grants. A block grant approach
12 would replace the FMAP-based federal match with fixed
13 state-specific lump sums. These lump sums would likely be
14 based on the current federal share of Medicaid and would be
15 indexed over time for inflation and population growth.
16 Block grants could be structured to provide states with
17 increased flexibility in designing their Medicaid programs.
18 The block grant approach limits federal liability
19 for changes in Medicaid spending due to enrollment growth
20 or due to growth in per person spending. An analysis by
21 the Congressional Budget Office of some specific block
22 grant proposals suggests that, over the long term, most

1 savings would come from holding the rate of growth for the
2 block grants lower than the historical rate of growth for
3 Medicaid spending.

4 Past proposals for Medicaid block grants that
5 we've reviewed have not included provisions to increase
6 grants in response to unexpected increases in enrollment or
7 spending, so states would need to increase their share of
8 funding or reduce program costs if spending would exceed
9 the grant.

10 So, block grants would provide greater
11 predictability and could give states a stronger incentive
12 to seek efficiency, particularly if they're coupled or
13 designed to include additional state flexibility.

14 The letter that we received from the Chairs of
15 the Senate Finance and the House Energy and Commerce
16 Committees requested that MACPAC identify considerations
17 related to using a capped allotment financing structure for
18 Medicaid, so we presume that they're asking us: what would
19 it look like if Medicaid adopted a financing structure
20 similar to that used in CHIP, that's been used in CHIP
21 since 1997. That structure maintains the FMAP-based match,
22 but puts a cap on the federal share through fixed annual

1 allotments.

2 Like block grants, this approach limits federal
3 liability for changes in Medicaid spending, but the match-
4 based approach requires states to still contribute some
5 state share.

6 So, a couple notes on how this has worked in
7 CHIP. CHIP uses a capped allotment structure, but the
8 formula for determining the annual caps has required
9 periodic adjustment. The caps were initially based on
10 estimates of need -- or as someone told me, "guesstimates"
11 of need -- and for the first several years of the program,
12 states' allotments tended to be much larger than their
13 actual spending.

14 As CHIP programs matured and states expanded
15 eligibility, several states were slated to experience
16 shortfalls relative to the size of their allotments, so
17 Congress intervened to appropriate additional funding so
18 that states would not run out of federal CHIP matching
19 funds. Congress also later changed the formula and the
20 caps to provide more funding in line with what states were
21 actually spending in CHIP, and now the caps are well above
22 what we see states spending.

1 So, capped allotments, like block grants, can
2 provide incentives for states to be efficient if the
3 allotment formula and the caps are structured to do so.
4 A third approach is per capita caps. This
5 approach would establish per enrollee limits on federal
6 Medicaid payments to states. That is, the federal
7 government would establish an annual per person spending
8 limit, similar to, like, an annual capitation payment,
9 based on spending in a designated base year. Some of the
10 proposals we've seen have had caps for major eligibility
11 groups, so there would be a cap for children and one for
12 adults and one for the elderly. Some have suggested that
13 there could be adjustments for things such as risk factors
14 or regional cost differences. There have been proposals to
15 adjust the caps of the highest- and lowest-spending states
16 to bring everyone closer to the national average and reduce
17 some of the state variation in spending.
18 This approach, like the others discussed, limits
19 federal liability for changes in Medicaid spending due to
20 increases in per person spending, but unlike the other
21 proposals, it does allow for cost increases resulting from
22 enrollment growth. The per capita cap model does encourage

1 states to focus on managing spending efficiently, hopefully
2 without providing incentive for states to reduce spending
3 by cutting eligibility.
4 And, like other models, there's a lot of details
5 to be worked out, including how to establish the per capita
6 caps for different states and different eligibility groups,
7 how the cap will be indexed over time as you get farther
8 from the base year, how much additional flexibility states
9 would have, and so on.
10 And the last approach I'll talk about is shared
11 savings. Alan Weil actually came in and discussed this
12 with the Commission at a meeting early last year. Shared
13 savings approaches blend a match-based approach like we
14 have now with per capita, caps by providing federal match
15 for state spending up to a target and then either reducing
16 the federal match rate for spending over the target or
17 allowing states to keep a higher percentage or basically
18 get a higher match if they keep their spending under that
19 target.
20 This approach provides some of the incentives of
21 per capita caps in terms of encouraging state efficiency
22 while limiting state risk if enrollment or per person

1 spending is greater than anticipated.

2 Descriptions of shared savings models have noted
3 that incorporating quality metrics or program performance
4 standards is an important thing to do so that states don't
5 seek to achieve their program savings through harmful cuts.
6 Other design considerations include how the spending
7 targets will be determined, how they will be negotiated
8 with states, and the extent to which states would have
9 flexibility to modify their programs.

10 So, to recap, you know, Congress has signaled
11 that they will be considering policy options for federal
12 Medicaid payments. MACPAC is not being asked at this point
13 to take a position on the merits of any of these proposals,
14 but we can provide input on technical and policy issues.
15 How should Congress establish an appropriate rate of growth
16 to be applied to caps or to targets? Should any
17 populations or services be excluded? You know: should the
18 duals be out? Should long-term care services be out? That
19 sort of thing.

20 There are policy questions to be considered, such
21 as the extent to which states should assume risk for
22 enrollment changes or assume risk for changes in per person

1 spending. And we can leverage the collective expertise of
2 the Commissioners to think through downstream effects on
3 states, enrollees, and providers.
4 So, this is the start in terms of where we could
5 go from here. What we'd like are your thoughts on the
6 kinds of analyses you'd like us to do over the next couple
7 of months to further inform this discussion.
8 CHAIR ROSENBAUM: Thank you, Moira.
9 So, I have two comments to let people sort of get
10 their comments ready to go. One is, again, going back to
11 the theme from the previous session, Toby's point that
12 within each of these proposals, there is always the
13 question about what state expenditures will be recognized
14 as qualifying for a federal payment, and it doesn't really
15 matter whether it's an aggregated allotment or a per capita
16 allotment or shared savings arrangement. The question is,
17 what will states have to do to qualify for federal funding
18 in terms of spending money.
19 The other thing I've noticed in my own work -- I
20 happened to be looking back at some of the proposals,
21 nothing like Mary Ellen's review, but back looking at the
22 block grant proposals of years gone by -- is that, of

1 course, a key difference in the proposals is whether they
2 use a national methodology for allocation or state-specific
3 methodology. I know there was a fundamental shift from
4 1981, when the methodology was going to be tied to state
5 conditions, to 1995, when, as I recall, the methodology
6 shifted to federal normative standards, which is the --
7 where you got into the issue of winners and losers even
8 more if you had a national aggregation and then tried to
9 allocate underneath that, as opposed to a state-specific
10 system. My recollection -- I could be wrong -- is that the
11 switch came because the state-specific system just simply
12 didn't save any money and both proposals were made in the
13 context of trying to save money, which is, you know,
14 totally understandable. So, you might also disaggregate at
15 that level.

16 [Off microphone.]

17 COMMISSIONER GORTON: So, one thing that might be
18 descriptive work and could be useful is part of what Sara
19 was talking about in terms of what the money goes to pay
20 for. So, the goods and services purchased by Medicaid in
21 the 1980s differ from the goods and services purchased in
22 the 1990s and certainly those which are purchased now, and

1 while it is technically correct to say that 95 percent of
2 the spend goes to health services, that requires a fairly
3 open-minded definition of what qualifies as health, because
4 some people would not characterize transportation, home
5 modifications, home-delivered meals -- I'm not evaluating
6 those. I merely think it's useful to point out that even
7 the fundamental change of OBRA '89 and expanded EPSDT
8 changed the nature of the program in fundamental ways.
9 And, I think it may be worth pointing out to
10 people that this is not their grandfather's Medicaid
11 program. An awful lot of good stuff gets done in the name
12 -- you know, it's somehow a social determinant of health
13 and so we should pay for that. And, again, I don't aspire
14 to judge that, but I think we should point out to people
15 that that's going on.
16 The second thing that I wanted to say was -- and
17 I've lost it. It will come back. Sara, you can go to
18 somebody else. It will come back to me.
19 CHAIR ROSENBAUM: [Off microphone.] Andy is
20 next.
21 COMMISSIONER COHEN: Okay. This is so hard,
22 knowing how to dive in in a useful and objective and

1 analytic way into a passionate conversation that's been
2 going on for many decades, but I wanted to make a couple of
3 suggestions.
4 So, this is certainly not -- nothing leads us --
5 nothing is a silver bullet that leads us to a solution, but
6 as I often say, maybe enough to drive you all crazy, I
7 don't think all the answers to our sort of issues and
8 challenges are in the Medicaid program, and there are
9 hundreds of other federal-state relationships and other
10 programs out there that really could be instructive. So, I
11 would love it if we could do just a little bit of
12 comparative work to look at maybe programs that have been
13 block granted, what was the experience and what happened,
14 maybe a program that has capped, you know, has an allotment
15 system or other, you know, other kinds of relationships and
16 just see if there are, whether by case study or whether by
17 any other kind of, like, analysis that's already been done.
18 I don't think we can do this all from scratch.
19 We can sort of generate some insights -- I mean, because
20 right now, we're -- you know, in some ways, we are trying
21 to imagine what a regime looks like that is not -- that
22 doesn't exist. It's very hypothetical. But, there are

1 insights, I think, that we can draw from the experience of
2 other federal-state programs. That's one suggestion.
3 I think the other one, and you've already been
4 doing this, Moira, but the driver here is sort of
5 sustainability. The driver is the growth in costs. And I
6 just think it's extremely important to sort of show what
7 have been those drivers over time and how they are
8 changing, because I think any proposal that aims towards
9 sustainability that is tackling last decade's driver is
10 going to -- is not successful.
11 CHAIR ROSENBAUM: [Off microphone.] Penny.
12 COMMISSIONER THOMPSON: Yes, so much to talk
13 about here. So, just to -- I'll try to just do a few
14 things that I wanted to mention.
15 One is that I'm not sure we're doing the current
16 arrangement justice when we talk about the federal-state
17 matching arrangement that exists today. We raise some
18 issues about the concerns of that, but that arrangement has
19 some positive benefits, as well, and I think that, you
20 know, one of those with regard to your point about the
21 federal government doesn't have control over how much the
22 states are spending, to some extent, I feel like the idea

1 of the federal match was that the states, by virtue of
2 wanting to be parsimonious and efficient with their own
3 dollars, would create that efficiency for the federal match
4 because the federal match would be following along in the
5 wake of the state expenditure.
6 And I think that point is not given enough
7 emphasis here, that at least as it's been operating in lots
8 of ways, although there have been issues that you've raised
9 that. But, you know, that idea that, yes, states have
10 discretion and states are making decisions, but because
11 they have their own interests to protect in their decisions
12 about state expenditures, that, by definition, also
13 protects the federal match associated with that.
14 With regard to the request and even our talking
15 about this, I just put a marker down about, like, our
16 definition of a block grant, or per capita formula, or
17 capped allotment. These things don't have specific
18 definitions, and so we might want to take advantage of that
19 by talking about the variability that you could build into
20 different approaches underneath some of those labels.
21 Again, that's a little bit of the earlier language
22 conversation. You know, we're making assumptions about

1 what we mean by that. But in actuality, if we were all
2 sitting down here with a charge to write a piece of
3 legislation to implement any one of those proposals, there
4 are many decision points that we would have about how to
5 think about that and how to do that.

6 And, so, we might just – even in an early stage –
7 want to signal that there's still lots of places that you
8 could exercise some decision points that could be important
9 to the program and to stakeholders.

10 And, with respect to that, I also think that
11 we've talked a lot about the evolution of the program and
12 the changes at the program. I think that some of these
13 concepts really have not been seriously discussed in a
14 period when we've done a lot of work around shared savings,
15 value-based purchasing, let's get everybody kind of
16 incented to be aiming in the same direction, let's think
17 about overall health, let's think about integration, let's
18 think, you know. So, it does seem to me that we kind of
19 need to -- and should -- kind of update some of these
20 concepts with -- and infuse it with some of that thinking
21 and say, how do those learnings now change how we begin to
22 think about some of these general concepts and how would

1 they find expression underneath some of these different
2 frameworks.
3 COMMISSIONER BURWELL: I do think that we need to
4 think creatively about financing mechanisms and payment
5 models. I mean, it is a program where the federal
6 government will match state spending without a whole lot of
7 -- you know, there's some parameters around state spending,
8 but we all know that state -- you know, federal Medicaid
9 maximization involves let's figure out how we can get match
10 for more and more things. And one of my favorite quotes
11 was a state DD director who said, "Well, our philosophy in
12 our state is if it moves, we bill it; if it doesn't move,
13 we depreciate it" -- which was, you know, we'll just bill
14 everything.
15 So I think value-based purchasing is a new
16 approach. It requires a whole different set of metrics.
17 But I'm just thinking more about, you know, what are the
18 outcomes we want to achieve and paying for that. I think
19 the balancing incentive program is actually a very kind of
20 primitive example of that because you're paying states to
21 achieve -- you know, you're giving financial incentives to
22 achieve a different balance of institutional versus

1 community-based care. I think there are more opportunities
2 around thinking about what outcomes states should be
3 achieving in the Medicaid program and tying money to that.
4 I think money changes behavior better than anything else.
5 CHAIR ROSENBAUM: Yes, and I just want to note
6 that, to your earlier point, I think it's also important,
7 Moira, to bring out the fact that there are certain federal
8 programs that assume the existence of Medicaid, and
9 Medicaid as it's currently structured. So, the child
10 welfare programs assume the existence of Medicaid. Special
11 education programs assume the existence of Medicaid.
12 There's no separate medical care funding under those
13 programs. Programs for children and adults with
14 developmental disabilities assume the existence of
15 Medicaid. The Older Americans Act assumes the existence of
16 Medicaid.
17 And I think that one of the things you might want
18 to point out about the various proposals is that it's not
19 only the effects on Medicaid that would have to be
20 contemplated by Congress, it is the effects on related
21 programs that in one way or another tie into Medicaid;
22 where it's not even so much a matter of the states'

1 flexibility over what's spending; it's that the federal
2 government has built entire infrastructures for states that
3 were conditioned on, you know, without saying so -- and
4 sometimes being very explicit actually, WIC assumes the
5 existence of Medicaid.
6 So all of these other programs that assume the
7 existence of Medicaid -- and maybe we'd want to think about
8 the spillover effects of changes as well.
9 COMMISSIONER GORTON: So in terms of additional
10 analysis, it may be that the recent experience in
11 Massachusetts sets a useful example here. So Massachusetts
12 moved to universal coverage in 2006 and more recently has
13 been tackling the issue of sustainability and the rising
14 costs of health care.
15 And to that end, you may be aware that they set a
16 statewide benchmark in terms of medical cost -- total
17 medical expense, and total medical expenses are supposed to
18 rise at a level at or below the rise of gross state
19 product, which is currently pegged at about 3.6 percent.
20 And, in fact, there's a whole variety of data being
21 published at the level of health plans, at the level of
22 hospital systems, and at the state level to demonstrate how

1 we're doing against that. And, in fact, we missed the
2 benchmark last year because Medicaid was at 5.2 percent;
3 everybody else was at or below the benchmark.
4 And what those data illustrate and ways that they
5 might be useful in this conversation are, to Penny's point,
6 states have made decisions, and so the trend rates of
7 growth in individual states, I suspect if you compare them
8 to their gross state products, you'll see variation in
9 which some states are growing a Medicaid program more
10 slowly than their gross state product, some are growing at,
11 and some are growing above.
12 And I think for the communities that express
13 concern that they pay federal taxes and it all goes
14 somewhere else, it is a useful talking point. In
15 Massachusetts, we have an ongoing, very active debate, and
16 probably a ballot referendum and a bunch of other things
17 going on, in terms of should the very expensive academic
18 medical centers continue to be paid multiples of what the
19 community hospitals are being paid for identical care for
20 identical people. And so there's actually a ballot issue
21 going out which proposes to cap and then take the money
22 from the rich hospitals and give it to the poor hospitals.

1 You could imagine an analogous suggestion -- and I think
2 you talked about it in one of these in terms of dialing
3 back the states that are growing faster and shoving that
4 money in the direction of states that are either managing
5 better or are struggling because they simply don't have the
6 resources to put to bear.
7 CHAIR ROSENBAUM: Thank you.
8 COMMISSIONER WEIL: Yeah, I'm trying to think
9 what our comparative value is here. Clearly, any big
10 proposal like this is going to generate a lot of interest
11 groups and others saying if you spend less, unless you
12 become more efficient you'll get less, which probably
13 doesn't really help policymakers. I think the emphasis
14 here really is on the -- what we can do is give some
15 insight into the technical complexities associated with
16 what seem to be fairly simple concepts, and part of the
17 reason a lot of the proposals that we went over in the last
18 section have never been reduced to legislative language is
19 because you'd actually have to be precise about things it's
20 a lot easier to not be precise about.
21 So I'm thinking of things like the complexity of
22 baseline. The debates over block grants all began with the

1 question of -- you're using two-year-old data. Do you lock
2 in interstate differences? Do you try to reduce them over
3 time, the whole state or federal trending? Lots of
4 measurement issues. I mean, if you’re per capita'ing, then
5 you have to put people in the right capita box. And we all
6 know that eligibility systems have not always been so
7 precise.

8 I also think there are some real administrative
9 federalism issues like accountability and leverage. I mean,
10 we just -- you know, two hours ago we were talking about
11 whether there should be federal standards over functional
12 assessment. Toby said, you know, CHIP started differently,
13 but the federal government keeps adding things to make it
14 more like Medicaid. I mean, you know, some of the
15 literature on block grants is that two things happen over
16 time: they shrink, and they become less block-like. They
17 have more strings attached. Not surprisingly, Congress
18 wants to do that. So, I think, giving some of that kind of
19 evidence.

20 And then I completely want to highlight Sara's
21 comment about the interaction between Medicaid and other
22 programs. I think this is very poorly understood, and

1 it's, again, a place where it's not that the answers are
2 right or wrong. It's just that there are lots of systems
3 in place built around the current structure that would have
4 to be revisited.
5 So it seems to me that this sort of -- instead of
6 this high-level “who loses, who wins” kind of stuff, which
7 I think there will be a lot of, you have to really
8 understand the program to understand the effects of
9 changes. I think that would be a great service.
10 CHAIR ROSENBAUM: So if I understand what you're
11 suggesting, essentially we might suggest certain kinds of
12 archetypal reforms that have emerged over the years, you
13 know, capped allotment, a per capita cap, whatever -- there
14 are a few of them -- and underneath each one identify the
15 issues and you could also show, comparatively speaking,
16 which issues are common to any of the financing reform
17 changes, which ones tend to be unique to those reform
18 changes, so that we are essentially drawing the requester's
19 attention to what specifically they're going to have to
20 think through if they do this, as opposed to the potential
21 global impact. Really, it's Penny's point, it's Alan's
22 point. Kit's made the same -- we've all made the point one

1 way or another. If you want to go down this pathway, here
2 is the taxonomy of what you're going to need to think
3 through.
4 COMMISSIONER WEIL: Just sort of to follow up, if
5 you want to save money, you could cut the FMAP. Then you
6 don't have to change anything structurally. Or you could
7 eliminate the 50 percent floor, and you would only affect,
8 you know, the 15 high -- but if you start -- once you start
9 looking at things that are more structural, you add to the
10 list of things. So it's sort of this continuum of
11 complexity.
12 CHAIR ROSENBAUM: Yes, and I'm very glad that
13 Alan flagged that because I think -- and it goes back to
14 the previous presentation as well -- that it's really
15 important to remember that in '81, of course, the
16 compromise for the block grant turned out to be a
17 discounted FMAP that lasted for a period of years. And so
18 I think that should be flagged as, you know, a way to go
19 when you're thinking about trying to save money.
20 COMMISSIONER WEIL: The point Penny made around
21 health care delivery and payment and how we talk so much
22 about driving these incentives differently I think is a

1 really important context. And then it gets to when we do
2 that with the delivery system, we don't just talk about
3 cost; we also talk about rewarding for quality and
4 outcomes. And I think there should be some thought of how
5 that's incorporated, that it's not just about -- you know,
6 to the extent we're looking at ways to reward and incent,
7 it's both on the financial efficiencies as well as the
8 outcomes that preserve the program as well as improve it.
9 COMMISSIONER THOMPSON: Right, and that's also --
10 you know, any one of these things, if you pick just one to
11 mention, you can get the wrong result. You know, you can
12 get a lower per capita cost by reducing provider payments
13 or making it harder to access services. And I don't think
14 that's what people want to do. I think they want to drive
15 a more efficient health care system.
16 So having data that shows that you're still
17 promoting access and quality and health at the same time
18 that you're doing whatever you're doing on the cost side is
19 one of the ways that you know that that result is really as
20 the result -- is happening because of efficiency and
21 transformation and not simply putting -- you know, reducing
22 the number of people who were eligible or cutting provider

1 payments and making them eat it without any kind of sense
2 of how they're going to make it up.
3 CHAIR ROSENBAUM: Any further comments?
4 [No response.]
5 CHAIR ROSENBAUM: Well, it has been a great
6 discussion, excellent presentation, terrific discussion.
7 Thank you very much.
8 So now we move to our final presentation of the
9 day, because seven was not enough. So now we need drugs.
10 [Laughter.]
11 CHAIR ROSENBAUM: And Chris is here to deliver
12 drugs to us.
13 ### **Review of Medicaid Outpatient Drug Role**
14 * MR. PARK: Thanks, Sara.
15 Today I'm going to provide a review of the final
16 rule on Medicaid outpatient drugs that CMS just released
17 last week, basically right about this time exactly last
18 week. The proposed rule was published February 2012, so
19 this has been a long-awaited final drug rule.
20 It generally implements and clarifies a lot of
21 the Medicaid drug provisions of the ACA. It also revises
22 other requirements related to outpatient drugs, including

1 key aspects of payment.

2 Although the rule is final, CMS is soliciting
3 comments on one particular issue that I'll mention later.
4 MACPAC is not required to comment, but given the attention
5 on drug spending trends recently, we wanted to provide this
6 session to give you a chance to learn about the updated
7 final drug rule and offer you an opportunity to consider
8 areas for future work on prescription drugs.

9 Today I'll be providing a quick refresher on
10 Medicaid payment and rebates for drugs so that you have a
11 context for some of the provisions of the final rule. I
12 will also then walk through some of the major provisions of
13 the final rule, including important dates, some of the
14 definitional changes and clarifications the rule makes,
15 talk about some of the payment limit and requirements that
16 the rule puts in place, and also some additional state
17 requirements of the final rule.

18 The final rule provides a lot of very technical
19 discussion and specifications on the prices and other
20 financial transactions that go into calculating things such
21 as average manufacturer price and best price. I won't go
22 into great detail on a lot of those technical

1 specifications but just try to highlight some of the key
2 aspects of the points relating to these changes.
3 So to quickly set the stage, Medicaid outpatient
4 drugs are an optional benefit, but it's provided by all
5 states. These are drugs that are typically -- you know,
6 they're dispensed from a pharmacy based on a prescription
7 that the beneficiary receives. Drug manufacturers must
8 enter into a rebate agreement with Medicaid in order to
9 have their products recognized for federal Medicaid match.
10 And, additionally, this rebate is separate from the payment
11 that goes to the pharmacy. So when we consider outpatient
12 drug spending, we have to consider both the state's payment
13 to the pharmacy as well as any of the rebates the state
14 ends up obtaining from the manufacturer.
15 The next few slides will provide a quick overview
16 of how Medicaid pays for prescription drugs. The payment
17 to the pharmacy contains two components. The first is the
18 ingredient cost, which covers the pharmacy's cost of
19 acquiring the drug. Typically this has been based on
20 published benchmark prices such as average wholesale price
21 or wholesale acquisition cost. Several states recently
22 have moved to actual acquisition cost as a basis of

1 payment, and as I'll mention a little bit later on, the
2 final rule does put actual acquisition cost into place as
3 the basis of payment going forward.
4 Additionally, there's a dispensing fee that
5 covers costs associated with the professional services to
6 dispense a drug to the beneficiary. Additionally,
7 beneficiaries may pay some cost sharing, usually a nominal
8 co-pay, and also managed care plans, since managed care
9 companies can provide a prescription drug benefit, they
10 usually use a typical similar structure of ingredient cost
11 and dispensing fees to pay the pharmacies, but often use a
12 pharmacy benefit manager to negotiate specific payment
13 terms with individual pharmacies.
14 There are some limits on payment that are put
15 into place by federal regulations and statute. The first
16 I'll mention is the federal upper limit, which is applied
17 for certain multiple source drugs, where there are three or
18 more products rated therapeutically and pharmaceutically
19 equivalent. The Affordable Care Act established the FUL at
20 no less than 175 percent of the average manufacturer price.
21 And the final rule does provide more clarification on
22 exactly how this will be calculated and which drugs and

1 situations it applies to.

2 Additionally, states on their own can also have
3 what are known as maximum allowable cost lists, and these
4 are similar to the FUL and often applied to generic drugs.
5 And often there are overlaps between the maximum allowable
6 cost list and the federal upper limit.

7 Additionally, states also limit payment to the
8 usual and customary charge of the pharmacy. An example of
9 this is where a pharmacy might offer a very common and
10 high-volume generic drug for $4. And so at the state
11 level, the state usually kind of compares all these prices
12 based on the different reimbursement formulas and pays the
13 lowest of those formulas.

14 On the Medicaid drug rebates, as I mentioned
15 before, drug manufacturers must provide a rebate in order
16 for their products to be recognized for federal match. In
17 exchange for these rebates, the state must generally cover
18 a participating manufacturer's products. The state has
19 some options to limit use through things like prior
20 authorization and preferred drug lists, but at a very high
21 level, they must provide some level of coverage for a
22 participating manufacturer's drugs. These rebates are

1 statutorily defined in Section 1927 of the Social Security
2 Act, and they're based on average manufacturer price.
3 As I mentioned earlier, these rebates are
4 separate from the state's payment to the pharmacy, and
5 because they're statutorily defined, the rebate amounts are
6 the same for every state for a particular drug.
7 One thing I should also mention is the rebates
8 are available on physician-administered drugs, so this is a
9 step -- this is a place where the rebate program extends
10 outside of what we would consider outpatient prescription
11 drugs.
12 As I mentioned before, the rebate formulas are
13 statutorily defined, and there are different rebates
14 applied to single source and innovator multiple-source
15 drugs, which are often called "brand drugs." The rebate is
16 calculated as the greater of 23.1 percent of average
17 manufacturer price or average manufacturer price minus best
18 price. And best price is the lowest price available to any
19 wholesaler, retailer, provider, or paying entity, with
20 certain exceptions for payers such as the VA or the 340B
21 program.
22 There's also an additional inflationary rebate

1 that gets applied if a drug's average manufacturer prices
2 has been increasing faster than the benchmark of the
3 Consumer Price Index.
4 For non-innovator multiple-source drugs, often
5 called "generic drugs," the rebate is 13 percent of average
6 manufacturer price. There is no best price provision for
7 generic drugs.
8 One change that was recently introduced through
9 the Bipartisan Budget Act of 2015 is that it now adds the
10 inflationary rebate to the generic drugs, and that goes
11 into effect one year after enactment. So we would see this
12 inflationary rebate start to apply the first quarter of
13 2017.
14 Another rebate provision that the ACA put into
15 place is an alternative rebate for line extension drugs.
16 These are the single-source or innovator multiple-source
17 line extension drugs that are oral solid dosage form. The
18 alternative rebate compares what the inflationary rebate
19 was for the original version of the drug and compares that
20 to the rebate that would be calculated for the line
21 extension drug under normal rebate formulas. And if the
22 inflationary rebate on the original drug is greater, then

1 the line extension drug would receive that rebate.

2 The Affordable Care Act increased the federal
3 rebate formulas. So for brand drugs, this rebate increased
4 from 15.1 percent of AMP to 23.1 percent of AMP. And for
5 generic drugs, it increased from 11 percent of AMP to 13
6 percent of AMP. Under the ACA, the federal government
7 keeps all the rebate dollars associated with the rebate
8 change above and beyond the old rebate formulas. So this
9 would be equivalent to 2 percent of AMP for generic drugs
10 and anywhere from 0 to 8 percent of AMP for brand drugs.
11 And it's 0 to 8 percent because of the best price provision
12 and how that price relates to 15 or 23 percent of AMP.

13 Okay. So now the provisions of the final rule.
14 First, here are some of the important dates of the final
15 rule. The final rule is effective April 1st, 2016.
16 Comments are due 60 days after publication, with
17 publication scheduled for around the beginning of February.

18 State Medicaid agencies have four quarters to
19 submit a state plan amendment to implement the average
20 acquisition cost methodology, mandated by the final rule.
21 This means the last date is for the state plan amendment to
22 be filed is June 30th, 2017, which could be effective April

1 1st, 2017.

2 Additionally, the provisions of the final drug
3 rule will be applied prospectively from the effective date,
4 so that manufacturers and states will not have to go back
5 and recalculate the rebates that have already been paid up
6 to this point.

7 As I said before, the final drug rule is
8 implementing a lot of the provisions in the Medicaid drug
9 rebate program related to changes from the ACA. Since
10 implementing the changes, the increases in the rebate
11 formulas, and the federal offset; it also puts into place
12 the alternative rebate for line extension drugs and sets
13 the maximum rebate at 100 percent of AMP, so that that is
14 the most manufacturers would have to pay, even though the
15 inflationary rebate might push it above 100 percent of AMP.

16 The ACA also extended rebates to managed care
17 programs so that the drugs -- paid for and dispensed
18 through managed care entities are now eligible for rebates
19 under the federal rebate program, where they weren't
20 previously.

21 The final rule also implements the definitional
22 changes to AMP and best price that the ACA put in place,

1 and it also establishes the federal upper limit as no less
2 than 175 percent of AMP.
3 Most of these provisions have already gone into
4 effect as the statutory provisions at the ACA were
5 effective without regard to promulgation of any final
6 regulations.
7 One of the new changes in the final drug rule is
8 that it revises the definition of states and the United
9 States to include the territories, and this will be
10 effective April 1st, 2017. CMS is giving the territories
11 and drug manufacturers a year to kind of work through some
12 of these technical changes that would need to be put into
13 place.
14 Previously, territories were not included in
15 Medicaid drug rebate program, but they may have received
16 territorial government-mandated price concessions or other
17 discounts from the manufacturers. CMS is going to allow
18 the territories to use waiver authority if they choose not
19 to participate in a drug rebate program.
20 The ACA changes the averaging manufacturer price
21 definition to what it is now – the average price paid to a
22 manufacturer for the drug in the U.S. by wholesalers for

1 drugs distributed to retail community pharmacies and retail
2 community pharmacies that purchase drugs directly from the
3 manufacturer. The final rule provides a lot of
4 clarifications as to who were considered wholesalers and
5 retail community pharmacies, what prices, discounts, and
6 other financial transactions are included and excluded from
7 the calculation.

8 For example, some of the exclusions include sales
9 to mail order pharmacies and hospitals, as these are not
10 considered retail community pharmacies, discounts to the VA
11 or 340B entities, as these are prices and discounts not
12 offered to retail community pharmacies, and also certain
13 things like manufacturer programs that have provided free
14 goods or discounts directly to the beneficiary and passed
15 fully on to the consumer and do not -- and the pharmacy
16 does not keep any portion of that amount.

17 Because the definition of average manufacturer
18 price is now tied to retail community pharmacies, there are
19 a number of drugs that are inhalation, infusion, instilled,
20 implanted, or injectable drugs -- these are also commonly
21 called 5i drugs -- that are not generally dispensed from a
22 retail community pharmacy and, thus, would not have an

1 average manufacturer price available to them.

2 So what the final drug rule does is put into a
3 place a calculation for these drugs, these 5i drugs, that
4 are not typically dispensed from the retail community
5 pharmacy. It allows manufacturers to make the determination
6 as to what qualifies as a 5i drug, if their product is a 5i
7 drug. It also establishes a standard where a drug is not
8 considered to be generally dispensed from the retail
9 community pharmacy if 70 percent or more of the units
10 dispensed do not come through the retail community
11 pharmacy. The proposed rule had initially proposed the
12 standard at 90 percent.

13 Line extension drugs are the one place where CMS
14 is still seeking comments on what should be included. The
15 rule has chosen not to define a line extension drug at this
16 point, and this is in part in response to many comments
17 regarding, for example, whether abuse deterrent
18 formulations should be considered line extension drugs and
19 subject to a potential higher rebate, where when other
20 federal policies are trying to broaden and encourage
21 development of these drugs to address substance abuse
22 problems.

1 The final rule is finalizing the rebate put into
2 place through the ACA for calculating the alternative
3 rebate, and it also has clarified that the alternative
4 rebate for line extension drugs will only be calculated if
5 there is a corporate relationship between the manufacturer
6 of the initial product and the manufacturer of the line
7 extension.
8 The final drug rule is also implementing the
9 federal upper limit at 175 percent of AMP. It has made an
10 exemption in cases where the calculated federal upper limit
11 at 175 percent of AMP is less than the average acquisition
12 cost as calculated from a national survey, which at this
13 point, they are going to use the National Average Drug
14 Acquisition Cost Survey, which is also called the NADAC
15 Survey, where they will bring up the federal upper limit to
16 be equal to the average cost from that survey.
17 The federal upper limit will also not be applied
18 to the 5i drugs that I mentioned previously when they are
19 not generally available through a retail community
20 pharmacy. Additionally, there is no smoothing
21 mechanism when to be put into place for the FUL calculation
22 at this time.

1 The federal upper limit will be finalized and
2 published in April 2016 in accordance with the effective
3 date of the final rule.
4 As I mentioned previously, the final rule is
5 going to establish actual acquisition cost as a standard
6 for ingredient cost. States have some flexibility in the
7 data and benchmarks they use to determine what actual
8 acquisition costs will be as long as they can demonstrate
9 that relationship and how it applies to the actual
10 acquisition cost of pharmacies.
11 They also amended the term "dispensing fee" to
12 "professional dispensing fee" to try to reflect that this
13 amount should reflect all the professional services and
14 costs that are in place to provide the drug to the
15 beneficiary.
16 The final rule states that the payment should be
17 consistent with efficiency, economy, and the quality of
18 care and provide sufficient access. So when states are
19 kind of setting their payment methodologies, they need to
20 take into account both the acquisition cost and dispensing
21 fee to make sure that is adequate.
22 Managed care organizations do not need to use the

1 average acquisition cost methodology, but payments must be
2 sufficient to provide appropriate access.
3 And states also have certain requirements. As I
4 mentioned before, they will have to file a state plan
5 amendment to put into place the average acquisition cost
6 methodology, and they must also consider and demonstrate
7 overall payment adequacy whenever they propose a change to
8 either the ingredient cost or dispensing fee.
9 Additionally, they must submit the payment methodology for
10 340B entities and any associated 340B contract pharmacies
11 as well as Indian Health Service, tribal, or urban Indian
12 organization pharmacies, as they may have different cost
13 structures and payment needs. And CMS wants to be sure
14 that the payment methodology put into place adequately
15 reflects the acquisition costs of these different
16 pharmacies, and that it reflects the efficiencies and
17 promotes sufficient access.
18 So this is kind of a very quick high-level
19 summary of the outpatient drug rule. As I mentioned
20 before, CMS is seeking comment on one particular aspect of
21 the line extension drug definition. MACPAC does not have
22 to comment on that particular provision, but we wanted to

1 give you an opportunity to kind of at least get a flavor of
2 what's included in this final drug rule and if there is
3 anything that might lead to future work that that you would
4 like to see on particular drugs.
5 CHAIR ROSENBAUM: Comments? Do we want to
6 comment? Plus, other comments? Anybody have feelings about
7 line extension drugs?
8 [Laughter.]
9 COMMISSIONER DOUGLAS: I was just going to ask if
10 there is any sense of the savings that they are projecting
11 based on this rule.
12 MR. PARK: I don't have that directly in front of
13 me. I think it's mentioned that the state and federal
14 governments will save approximately $2.7 billion, and cost
15 of drug to manufacturers and states, approximately $431
16 million. But I didn't exactly write that down, and a lot
17 of that has to do with definitional changes to AMP and how
18 that will play out, the changes to the federal upper limit
19 and things like that.
20 CHAIR ROSENBAUM: Andy.
21 COMMISSIONER COHEN: Just a question. I have no
22 idea if you know the answer or if there is an answer, but

1 obviously this space is just sort of -- it's terribly
2 complicated, and as a result of it being terribly
3 complicated, it's been terribly sort of not well
4 implemented. And the only evidence I have for that is
5 every day, there is an article in the paper about a
6 multimillion-dollar settlement for all the rebates that
7 weren't collected or the calculations that were done wrong
8 or whatever, and that continues. And that has been for
9 decades now, so I guess I'm just wondering if you have a
10 sense of does anything in here sort of go to either, like,
11 clarifying things or simplifying things in such a way that
12 that sort of program integrity issue would be differently
13 addressed.

14 MR. PARK: Sure. I think it definitely provides
15 clarification on exactly what prices, discounts, and other
16 financial transactions go into the calculation of the best
17 pricing and the AMP, where previously the ACA had made
18 statutoral definition changes, but it wasn't exactly clear
19 as to exactly what things could be included and excluded,
20 exactly who qualifies as a retail community pharmacy and a
21 wholesaler.

22 So I think that will help kind of standardized

1 what manufacturers are doing and including in the
2 calculation of AMP. So I think that going forward should
3 be a little bit more clear and provide some of that sense
4 that at least people should be -- manufacturers should be
5 calculating it in a similar manner.
6 CHAIR ROSENBAUM: It is so nice to end the day on
7 an easy subject. Any other comments, thoughts,
8 observations?
9 I didn't see a rousing level of enthusiasm for
10 commenting on the rule, so I assume the answer to the
11 question that you ask is no.
12 I mean, I have to say Chris does an unbelievable
13 -- for those of you who are new to MACPAC, we are
14 incredibly fortunate to have Chris. We're incredibly
15 fortunate to have everybody, but every time I hear Chris on
16 the subject of drugs, I am reminded again just how on top
17 of drug policy and Medicaid he is, and it's great to have
18 his briefing, so thank you.
19 MR. PARK: Thank you, Sara.
20 CHAIR ROSENBAUM: So we have now -- it's like Car
21 Talk. You know, you have now reached the point where we
22 are at the end of the day, and it's time. I won't say that

1 you've wasted a perfectly good day. That's what Click and
2 Clack would say, but we are at that point in the day where
3 it's time for public comment, so the floor is open, if we
4 have January 28, 2016 commenters.

5 **### Public Comment**

6 * [No response.]

7 CHAIR ROSENBAUM: Seeing no commenting, we are
8 adjourned.

9 [Whereupon, at 4:42 p.m., the meeting was
10 adjourned.]

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