PUBLIC MEETING

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

Thursday, May 19, 2016
9:42 a.m.

COMMISSIONERS PRESENT:

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ANDREA COHEN, JD
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ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:42 a.m.]

CHAIR ROSENBAUM: All right. We are two minutes away from start time.

[Pause.]

CHAIR ROSENBAUM: Good morning, everybody. Welcome to our May meeting. As is always the case, there is a conspiracy in all buildings to make sure that women never get back to a meeting on time. So I think we all made it through the battle of the restroom.

So let's get started, and our first order of business this morning is the Commission's discussion, deliberation, and vote, a recorded vote, on a draft conflict of interest policy for the Commission. This policy has been developed in response to a request from Members of Congress that we have such a policy. We think that the request was a reasonable one and one that is very appropriate for us to implement. And we have brought in counsel for this undertaking who are quite experienced in conflict of interest work in public and private nonprofit entities.

And what we are going to do is hear from counsel.

They will present the key elements of this policy. The discussion and the vote today is on the policy. There are a number of implementation steps which obviously will take place once we put the policy into place. The policy, when finalized, will be posted publicly, and I look forward to a really important discussion, and I'm sure it will be a very rich discussion.

So, with that, why don't we turn to counsel to walk us through the policy, and then we will start the discussion.

REVIEW AND VOTE ON CONFLICT OF INTEREST POLICY

* MS. HEFFERNAN: Thank you and good morning, and thank you so much for inviting us here to present the proposed policy on Commissioner conflicts of interest for consideration by the Commission. My name is Kate Heffernan. I am going to present some of the background concepts that underlie the policy, after which my colleague, Mark Borreliz, will provide an overview of the policy itself.

So in developing the proposed policy, there were several goals. The first was to articulate standards for what might constitute potential Commissioner conflicts of

interest. The second was, given the primacy of transparency in MACPAC's operations, to ensure continued and enhanced public disclosure regarding Commissioner interests, affiliations, and conflicts. The third was to create a mechanism through which we could identify and respond to potential Commissioner conflicts of interest when they are identified. And, finally, to delineate certain activities that are simply prohibited and may not be undertaken by Commissioners during their tenure at MACPAC.

I want to draw an important threshold distinction between interests that an individual holds and conflicts of interest that are subject to the proposed policy. Every person, including the members of advisory bodies, has various interests. These can be across different aspects of one's life, professional, personal, political, financial, and that is just a fact of life.

A subset of such interests may, depending on the circumstances, raise potential conflicts of interest. A further subset of such conflicts of interest may raise concern to such a degree that an individual should refrain from taking certain action in order to avoid having the

conflict interfere with their primary obligations.

This is a winnowing funnel, and it is important to stress that the vast majority of interests held by an individual will neither have nor appear to have any undermining effect on the work they do and, as such, can really co-exist without impact. The proposed policy is intended to apply this general framework to the work of MACPAC.

The first important question is, What do we mean by a conflict of interest? The concept of conflict of interest is one that has received a great deal of attention, both in the ethics literature, in regulation, and in policies across all sectors of industry. The proposed policy before the Commission draws from this background and is focused on responding to those interests that could interfere with or appear to a reasonable person to interfere with the judgment that a Commissioner is obliged to exercise in the performance of MACPAC responsibilities. So the goal in this definition is to guard against the prospect of personal gain or other divided loyalties impacting a Commissioner's work and service to MACPAC.

In defining what a conflict of interest is, it is equally important to draw a clear line at what it is not. Holding an opinion shaped or informed by one's intellectual framework, professional viewpoint, personal experiences, and business relationships is not a per se conflict of interest. Opinions and the experience from which they arise do not necessarily interfere with or even appear to interfere with one's ability to discharge primary responsibilities such as serving as an appointed member of an advisory body such as MACPAC.

In fact, the statute authorizing MACPAC explicitly requires that Commissioners be chosen in part for the diverse knowledge and viewpoints they possess as a result of their backgrounds, associations, expertise, and scholarship, among other things. The statute includes a detailed, lengthy, and varied set of required perspectives that must be represented through MACPAC's members. Examples include individuals with direct experience as enrollees, individuals with national recognition for their work in the health care sector. It requires a mix of representation based on geography, profession, urban versus rural environments, et cetera. And, in fact, the statutory

requirement recognizes that the true value of an advisory body such as MACPAC depends on the diverse experiences and perspectives that the members bring to the work that they do.

So the challenge before us was to create a policy that preserves that legally required representational diversity intended to enhance the work of the Commission while creating a process to protect against conflicts of interest that could detract from that work.

* MR. BORRELIZ: Let me go on now and very quickly take us through the anatomy of this policy and the machinery that would be put in place in order to implement the system.

The machinery is very simple, and it is a very straightforward process. It begins, as you can see there, with information collected from the individual disclosure statements that Commissioners routinely file. Information is then submitted to essentially peer review or third-party review, independent review, and that takes the form of a committee that I'll describe to you in a moment, a conflicts of interest committee.

The conflicts of interest committee's charge is

to examine certain of the interests that carry a heightened risk of actually spawning a conflict. The committee would examine that subset of interests and determine whether, in fact, there was the possibility of a conflict of interest, whether it was problematic, and could go on then even to make the recommendation that the affected Commissioner recuse from the ultimate vote on the recommendation with respect to which the Commissioner was conflicted.

A very important point throughout the process that the policy calls for is transparency, again, going back to Kate's point about the primacy of that consideration in all of MACPAC's operations. So as we go along, I hope that the devices by which transparency will be achieved throughout that process will become apparent. So let's see how we did.

Let's go back to that first step of disclosure. There were wonderful tools to use for this purpose. What we recommended was that MACPAC use two forms: GAO Form 675 and GAO Form 725. We considered other forms but found these to be the most detailed and perhaps the broadest. So they simply provided a great wealth of information to begin this winnowing process.

Two documents, GAO Form 675, which includes, among other things, disclosures of earned income, investment holdings, gifts received by Commissioners and their families, and positions, affiliations held by Commissioners. In addition, a new form, Form 725, was developed originally with the thought that this would be used to vet and select appointees to MACPAC based on a review of their involvement in substantial political activity, advocacy, and litigation.

The policy now calls for having both of those forms considered and renewed annually. That is not true -- that is not a change for the first form, but for the second one it would be. So it's actually expanding the frequency of disclosures. It is also expanding the frequency of disclosures by requiring that Commissioners update their forms on file by reporting material changes to the executive director.

Now, we have a lot of information generated in that way. As Kate emphasized, not all of these interests by any means are problematic, and a job of winnowing and zeroing in on particular interests of concern will fall to this conflict of interest committee. The committee will be

composed of five to seven Commissioners. It will be chaired by the MACPAC Chair, who will be numbered in the five to seven Commissioners. And their charge will be to undertake this review I described.

When will they do that? They will do that in the weeks, month, months that precede a meeting at which a recommendation will be coming to a vote. And as I understand it, it is the common practice of MACPAC that they are able to arrive at that point of knowing what the recommendation will look like with plenty of time for this type of review.

Four types of interests will be the focus of review. First will be equity in a health care company or in a publicly traded company held by a Commissioner, if that equity exceeds $50,000 and if the value of that equity could be affected by the vote on the recommendation that is to come up.

When I say "affected by," you will see at the bottom of the slide that we made that a defined term to indicate that it can't be something speculative or far-fetched. It implies that the effect of that vote on the financial interest must be direct, predictable, and

significant.

A second bucket of interests will be gifts received from any single entity that aggregate more than $5,000 over a 12-month period, and these have to be gifts, again, from an entity or an individual financially interested in the vote; their financial interests could be directly, predictably, significantly affected.

The third category is for earned income that exceeds $50,000 in the aggregate over a 12-month period from any entity or individual, again, financially interested in the outcome of a vote.

And, finally, Commissioner service as a director or officer of an entity, whether it is compensated or uncompensated, that has that same financial interest in a vote -- in other words, where the vote outcome would directly affect the financial interests of the outside entity.

As I had said, the committee will review those interests to see if any of them appears to pose, with respect to a Commissioner and having in mind the recommendation coming up for a vote, whether there is a potential conflict of interest. If they determine that

there is a conflict of interest, first, that is a disclosed fact. That becomes something that will be a matter of public record, again, in service of transparency considerations.

The committee will not itself decide whether recusal is required on the part of the Commissioner, but instead will make a recommendation, if it chooses, to direct the Commissioner to consider that, consider recusing.

Now, remember, as I said earlier, it's known for a while in advance of a meeting that a recommendation will be coming up for a vote, so that means that for one thing the committee will have time to do its work carefully. The Commissioner, informed of a potential conflict of interest, will have the opportunity to consider it searchingly as well, and also to make this difficult discussion of whether it warrants recusal from the vote.

As a general matter, whether or not a conflict of interest is surfaced through this process of committee review, Commissioners will be reminded prior to every meeting at which a recommendation vote is scheduled that they need to give thought to whether or not they have other

conflicts of interest of any nature such that they feel they are compromised in their ability to render an evidence-based vote. So in that case as well, where the Commissioner volunteers something that simply does not appear in the disclosure forms and wasn't the subject of COIC consideration, in that situation as well, any disclosed interest will also be a matter of public record.

So in the end, the objective of transparency is being served in many ways, and we think that's absolutely critical here because transparency really is the starting point, the necessary -- not necessarily sufficient, but the necessary cornerstone for integrity. In this case, you've seen that the interests of Commissioners are going to become transparent in many ways. One that we haven't discussed is simply that as among the Commissioners themselves, MACPAC members will know a great deal about each other's interests and outside affiliations, and that comes about naturally through the deliberative process.

In addition, through the GAO reporting forms, you'll have lengthy and complete disclosures of a great deal of information. Some of that may find its way to the website so far as Commissioner affiliations. Those

interests will also appear in meeting materials. And then, as I've probably harped on too much, there will be many instances for public disclosures of anything that comes of this conflict of interest process. So identify conflicts of interest, will be a matter of public record; if anyone chooses to abstain from voting as a result, that will be noted, as well as the reason for the abstention.

It's a pretty simple process, as I said. So as a final point, I just want to return now to the couple of prohibited areas -- a couple areas of prohibited activities. These aren't necessarily conflicts of interest. To some extent you can look at them that way. But it's probably better to consider these conditions that are really inconsistent with the role that MACPAC plays, with the obligations of the Commissioners to uphold that role and to uphold the reputation of MACPAC for integrity and impartial, nonpartisan advice to Congress.

The first prohibition is on involvement in litigation. As you see there, a Commissioner may not participate either as a party or as an amicus curiae in litigation if it relates to a federal health care program and either House of Congress is a party to the litigation.

It's simply in a way -- the inconsistency here is simply the duty of loyalty that is owed to Congress, and this seems simply to be a contradiction of that.

The second area of prohibitions relates to involvement in substantial political activity, so a Commissioner will not be allowed to be a paid employee or consultant with a political campaign or to act as a formal surrogate for a campaign or candidate, or as you see, engage in sustained public involvement in forming policy positions on behalf of a campaign, office holder, or candidate. In all of those respects, there's the danger that the Commissioner will be identified with the interests of a party and to such a degree that they really cannot be separated and there's the danger of a political cast now reaching or tainting the role of MACPAC.

We felt that this is a robust policy, especially for an entity like MACPAC that has so many guarantees already against conflicts, that operates so much in the sunshine. So I'll let it stand there. That's the totality of our proposal.

CHAIR ROSENBAUM: Thank you very much, Mark.

Before we open it up for discussion and comments,

I am going to ask Anne to summarize the feedback that she received on the draft policy from a number of different sources.

EXECUTIVE DIRECTOR SCHWARTZ: Sure. We sent out the draft policy about 10 days ago to majority and minority staff at Energy and Commerce and the Finance Committee, also to GAO, CBO, and MedPAC. In addition to the policy that's before you today, we also sent out a summary of MACPAC policies affecting conflict of interest and activities of staff.

MedPAC had some questions about how we would operationalize and implement different aspects of the policy, but no comment on the elements. CBO did not respond, although I didn't expect them to. It was more of a courtesy for the time their General Counsel spent with me.

GAO told me that they had a favorable impression of the policy, that it had all the elements, and in fact wanted to be sure that they had a copy of the final policy, so they can use it to inform prospective Commissioners when they do the next round of appointments.

In terms of feedback from the Hill, both Senator

Wyden's staff and Congressman Pallone's staff from the Democratic side thought that we had done a good job. Pallone's staff actually said we had gone above and beyond in responding to the concerns of members.

Senator Hatch was a signatory to the second letter that we received from the Hill on this matter. Senator Hatch's staff person told me that she felt that we had addressed all the issues raised in the March 29th letter, and that we had done a good job of that.

The staff for Mr. Upton and Pitts continue to be concerned and had five areas of concern. One is they continued to be concerned about what conflicts constitute a conflict of interest and how those will be managed, they were particularly concerned about both financial activities and conflicts that would be non-financial. They thought that the review by the Committee should not be advisory, that it should be binding. They thought that all litigation should be a prohibited activity, except when undertaken as part of the Commissioner's full-time employment. They thought that similar rules of conduct should apply to Commissioners and staff. And I should mention for the benefit of the audience that staff

activities are significantly more restricted than the Commissioner activities when it comes to political activities reflecting the fact that we're full-time government employees and Commissioners are not. And finally, they expressed concern that a recusal would only apply to voting, and they thought it should perhaps apply to discussion as well.

CHAIR ROSENBAUM: Thank you.

All right. So discussion? Questions? Comments?

Kit.

COMMISSIONER GORTON: So I'd like to thank counsel and the staff for putting together what I think is a pretty solid and reasonable response to the concerns raised by the committees, and I would agree with Senator Hatch's staff that it is a good effort. It will serve the Commission well in terms of underscoring, as I think you said, Mark, our necessary loyalty to Congress, and I am supportive of the policy as it's drafted.

CHAIR ROSENBAUM: Alan.

COMMISSIONER WEIL: Yeah. I want to also express appreciation for the work here. When I think about the purposes expressed for having the policy, I sort of divide

it into two categories. One is to have a clear process that promotes transparency, and I think you've done that above and beyond and feel very comfortable operating within that.

The area that I have questions has to do with providing us actually with guidance, and I sort of have both a specific question and a more generic question from your experience, which is the policy basically has quite general language, which is helpful because you can't anticipate every situation. But then the burden of interpreting that language has shifted to us, both as individuals and collectively, and this is not what we all do for a living. It may be what you do for a living.

And so my process question is whether it is typical to leave determination of conflict to a lay -- or maybe not completely a lay, but certainly not a trained-in-conflict group. So from a process perspective, is it the norm to say, "Yes, you determine yourself and the committee of yourself determine," or is it more typical to have some sort of a process that involves people like you who are experts? So that's my first question.

My second, to sort of illustrate the point of the

challenge I feel we could confront and how I'm not sure whether this will meet the needs of those who have requested we do it, I pick this example not to pick on anyone but because it's real. We know we have on the agenda, discussion of allocation of disproportionate share hospital funds. If we have a member who is an employee of a disproportionate-share hospital, it seems likely that our recommendations would in general, if we're recommending how those funds should be allocated, could have a positive or negative effect on someone's institution. So I just use that as an example.

When I read this, I don't know whether that's a conflict, and if I don't know, I am trying to figure out what we gain and what the public gains by us having this policy. So it's a process question and a question of what level of specificity is helpful, and frankly, if you could answer the question of whether that's a conflict, I'd be interested to know.

MR. BORRELIZ: Actually, let me start with that DSH one because I know that's a real bugaboo in the minds of many people, and rightly so. It's a tough problem.

Now, let's say you have a recommendation

concerning tightening up DSH payments or now creating some other types of entities that will divert funds away, Medicaid funds away from DSH payments. That does not mean -- you do not need to read that, therefore, the hypothetical you gave as a conflict.

There are many ways of dealing with policy-related impacts, and among, for example -- there is a very good precedent in the federal government. The Office of Government Ethics on the executive branch side actually differentiates between impacts that affect a class as opposed to impacts that bear on a particular, say, DSH hospital.

I think there's room under the standard being given to you, so far as what is a direct effect. I think that your committee would have the ability to say, "Well, we're going to effectively adopt that same kind of reasoning because we do feel that if this were a class-wide impact and all DSH hospitals are going to benefit or lose," then anybody who is here from a DSH hospital is, in a way -- has an especially valid basis to speak to that concern as a larger concern.

If it were to benefit only one hospital -- and

it's harder to say that you are really -- your policy input is based on larger concerns like that -- there, you might want to draw the line and say, "No. It's in separable that there will be benefit to your institution only, and we would recommend that you not vote on that one." So you can do a little bit that way as well.

You're right. We've left you with very few guidelines. Part of that is the nature of the business. Part of that is our hope that -- and our experience with many institutions that they do better to sort of develop their own kind of precedents and norms for that institution. This is such an interesting body because of its representative capacities. So you might do well to develop your own for a while.

Could you have outside advice as well? Absolutely. Sure.

CHAIR ROSENBAUM: Mark, can I ask you one follow-up? I was sort of, in fact, thinking of almost the same example. At some point, I assume when the Conflict of Interest Committee evaluates any particular set of interests in connection with any particular vote that's upcoming, that we are also limited in what we define as a

conflict by the statute itself.

So, for example, if we had a hospital CEO, a CEO of a hospital happened to be a DSH hospital, who drew a salary from the hospital, and the hospital was part of a broad class of hospitals that might be affected, at some point we do have to confront the reality of our statute, which requires that the viewpoints of Commissioners be heard, not just sitting here taking in information but actually voting. So I assume that that consideration also tempers how we would treat what is a concrete and particularized conflict versus a general policy question.

MR. BORRELIZ: I think that is an absolutely legitimate, organic consideration.

COMMISSIONER MILLIGAN: Hello. Three points, and I want to follow up on this DSH example. I think this is a good example.

CHAIR ROSENBAUM: No offense to Sheldon.

COMMISSIONER RETCHIN: No, I am sitting here thinking.

COMMISSIONER MILLIGAN: You are heading where I am heading with this, Sheldon.

So let's say that there was going to be a vote

about DSH, and hypothetically, let's say it was to vote to get rid of DSH and to put those federal resources into a CHIP transition coverage expansion, insurance directly. As a class, the committee might say -- and I am going to come back to the committee in a second. But the committee might say no individual person has a conflict because it affects a class; therefore, the committee might not recommend that anybody recuse themselves. Then the Commissioner can decide whether to declare and recuse based on their own searching of their soul.

Let's say everybody votes because they're bringing their expertise to bear, which was how presumably they were appointed by GAO, and then let's say the vote is that the Commissioners with a relationship with a DSH hospital vote against my hypothetical to dismantle and get rid of DSH, everybody else votes in favor, that will affect the weight of our advice as an advisory body to Congress.

I would think that would be a natural way this would play out, that to the extent that we don't have a unanimous vote, people will look to see whether it will affect the weight of the vote, and the MACPAC thus far has, I think, had solely unanimous votes. It will affect the

weight of it. I can see that completely playing out fairly that way.

And so I guess I want to come back to the initial point I want to make, is I think where this is going to need to get addressed, is the committee, the COIC's procedures about class versus individual and all of that stuff. But in that case, my example about DSH, it may well be that no recommendation of recusal comes out of the committee. But I think the place where that really needs to get specified then is in the procedures that would emanate from the policy.

Two other, hopefully, quick points. The first is there is a different kind issue that I want to raise and make a suggestion, which is by virtue of our membership on the Commission, we're subject to -- we receive nonpublic information in terms of materials and discussions and so on, and I do think that as a companion piece to this policy, we should make sure that in the roles and responsibilities for Commissioners that we don't disclose to anybody with a third-party interest anything that we're receiving confidentially and not available to the public, not in this policy, but I think we should reflect that on a

roles and responsibilities document that I would hope that we would consider posting on the website to give the public some confidence that we are taking that part of our -- the privilege of being on this Commission, we're taking that seriously.

And the last, I guess, comment I want to make is -- and maybe there is a question here -- is my understanding of the way it would work is, if the COIC in fact says we recommend recusal or you should consider recusal, it almost shifts the burden on the Commissioner to say, "Here is why I think I can vote. It's because I have this longstanding interest in it. I have this expertise." But it puts scrutiny on the Commissioner in those, perhaps, rare situations to the burden shifts, why they will offer a vote, which I think is perfectly fair and reasonable. But I just maybe want to ask whether that is your intent in the policy, how it would play out that way.

MR. BORRELIZ: Yes, as far as that intensification of soul-searching. I think that is a consequence that comes about by virtue of setting up an independent review body, and having that out there as a public matter that they at least feel that there is a

conflict of interest, I think that really -- that does heighten the stakes for the affected Commissioner to really give due thought to it.

I also want to just comment on how you're so right about there are many aspects of the statutory design that in a way mitigate the need for stringent conflict of interest concerns, and you put your finger on one when you identify the fact that what is coming out of this group is a recommendation to Congress. It is not a law. It is being placed in another forum where God knows how it will percolate its way through their deliberations.

MS. HEFFERNAN: And a dilution of consensus that you identified, I think is a great example of how the process itself allows for the different perspectives to be brought to bear in a way that results in a recommendation that reflects that in a transparent way.

CHAIR ROSENBAUM: All right. We have Toby, Gustavo, Penny.

COMMISSIONER DOUGLAS: The discussion on the class, this example with the DSH and either class or individual, has been really helpful. As I step back and I think of this and the intent of Congress and the idea of

diverse viewpoints and then having a Conflict of Interest Committee that then leads to recusal of different viewpoints, it just seems diametrically opposed to what was the intent.

That being said, if there is this clear definition, which I think either we need to, at a later date, have those policies made public or if we're going to vote on this maybe put it now, this clear definition on what we're talking about is really important around class versus not.

So I changed my thinking just now. As I hear that, that would make it a lot clearer, and so I just put that out there as something we should think through as either later come back with policies that are clear and so that no one outside -- everyone understands, whether future Commissioners, what we're talking about here, or the public.

CHAIR ROSENBAUM: I have had the same reaction. I have put giant stars around the distinction, and I am going to bring us back when we're done with questions to page 5, lines 14 through 18, whether that's a placement or whether there's another placement that would work better,

but I think this along with the limits imposed by statute itself, that there are certain situations that under certain circumstances might be a conflict, but by law cannot be a conflict because of the structure of the statute itself are two points that we probably want to capture in the policy and more potentially in the formal preamble to the policy.

So now we have Gustavo.

COMMISSIONER CRUZ: So I have a follow-up to Chuck's question, and it's mainly procedural. After the COIC reviews a potential conflict of interest of a Commissioner and determines there may be, and is informed to the Commissioner and he or she decides if they want to recuse or not, that process happens in public in the session? Or is it a private conversation that then is reported back to the whole Commission?

CHAIR ROSENBAUM: So this is the recusal advisory.

COMMISSIONER CRUZ: Yes.

CHAIR ROSENBAUM: Were there to be advice on a recusal, is that a private discussion or is that published?

COMMISSIONER CRUZ: Yes.

MS. HEFFERNAN: As currently conceived, I think the idea would be that that discussion would occur in advance of the public meeting. What would be publicly disclosed at the meeting would be the identification of a conflict, if that had occurred, and to the extent a Commissioner determines after hearing the recommendation of the COIC that he or she is going to elect to abstain, that abstention would also be public and the reasons for the abstention would be public.

So there are elements of it that would certainly be public, but the process itself we had envisioned in the policy occurring in anticipation of the meeting as part of the, you know, regular background work that occurs in advance.

COMMISSIONER CRUZ: And the second part to the question, would that be then -- that will be part of the minutes of the meeting, but not necessarily as part of -- or an end note or note to the actual vote or actual recommendation?

MS. HEFFERNAN: To be fair, those details I think are still to be determined. The idea of transparency and what portions should be made public is certainly covered in

the policy. The precise mechanisms through which the Commission elects to do that, I think, you know, there are various ways to approach it, and it could be done in different ways, depending on what the Commission feels is most appropriate.

COMMISSIONER CRUZ: Thanks.

CHAIR ROSENBAUM: And just to note again, we will be working on this, the conflict of interest review committee, should we approve this policy, will be working with counsel to come back to a series of implementation procedures that will attempt to capture all of this, procedures that are as clear as we can make them for people.

COMMISSIONER THOMPSON: Yeah, a few comments and then a question. One, thanks to everyone who has worked on this. I think this is a really good structure.

I wanted to come back to the -- oh, and I want to endorse Chuck's idea about a published code of conduct that would ensure that we're clear about our obligations about retaining confidentiality and so forth of some of the discussions and materials that are not public.

I want to come back to this question of a class

because I think it gets to this question of what is directly, predictably, and significantly. And I thought I was tracking on the conversation, and it's helpful because I think currently we're saying, well, it's not directly, predictably, and significantly if it is just affecting the general economy. But that's just so obviously not directly, predictably, and significantly. It would be more helpful, I think, to provide a little bit more guidance about kind of what falls on a line versus what doesn't fall on a line.

But I did kind of lose the thread in some of the interplay between Sara and Mark about the relationship of that to the statute. So I'm just wondering if we could pull that thread a little bit more and what we mean by that. Are we saying that you could have an interest that's disclosable that might even merit recusal, but that somehow because of the MACPAC statute would be excepted from the requirement for a recusal? Can you say a little bit more about what you mean by that?

CHAIR ROSENBAUM: Sure. What I was trying to get at is this very profound, sort of fundamental issue that I think, you know, Kate and Mark have come to struggle with

just the way we're all struggling with it, which is that the statute envisions a collection of people who have a formal relationship to the Medicaid program. Some of us have the relationship, like in Leanna's case, because they're actually used, the benefits and services. Some people around the table may have a formal relationship to the program because their jobs, their jobs in the world when they're not special employees have to do with the Medicaid program. They're running the program or they're running the related CHIP program. They're running a health plan. They're running a hospital. They, like Brian or you, are senior people in large firms that do a tremendous amount of analytic work around Medicaid. Like Peter, they treat children potentially who are on the program; or Herman, in your former life; Toby, a former director. We all have this relationship, and many of us have salaries that draw on this. Even in my case, while I'm a professor at a university, I've done a tremendous amount of analytic work on Medicaid, and I have major grants that have me doing analytic work on the Medicaid program.

And so at some point, the fact that we have formal relationships to Medicaid is what have propelled us

into the positions we hold today. We were deemed to be by GAO the types of individuals who could bring an enriched view and discussion. We don't revert to type. We sit here as special employees. We are special employees when we're here. So we're not here representing the West Virginia Medicaid program or CHIP program or Truven Analytics or whatever. We are here, though, because of our tremendously shared experiences, and because we are only special employees, a great proportion of us who are sitting here are sitting here salaried in ways that affect -- that can be affected in the broadest sense of the word by Medicaid policy decisions.

So I understand two checks to be in play in the work of the conflict of interest committee as we implement it. One is this very excellent point that we want to capture that there is a key difference -- I'm a lawyer, so I think of it as standing. It's the difference between a concrete and particularized interest, i.e., am I being hurt? Or do I have a general beef? You know, the second doesn't get you into court. The first does. It's at the point at which a Commissioner says, "Am I being hurt?" particularly on this all crucial third question, that we

have this individual versus class-wide effect.

But the second check on us is that inherently because we are here given our connection to and relationship with the Medicaid program, many of us at any given moment in time may draw compensation from entities that have to do with Medicaid, and it would be an absurd result in reading our own conflict of interest policy to decide that the mere fact of compensation is enough to trigger not a recusal but even the appearance of a conflict or a possible conflict. It has to be more than just your salaried entity because it is our job as Commissioners to consider these issues. And if all of us who were connected in some way to Medicaid had a conflict, if that's what the conflict of interest committee did, we would have nobody voting.

So we have two checks on us. One is this issue of concrete particularized interests, and the other is to avoid what courts call all the time "absurd results." We want to avoid absurd results. It would be an absurd result if we all were declaring conflicts every time we held a vote. It sort of almost goes without saying that we bring these interests to the table.

COMMISSIONER THOMPSON: If I could just respond to that for a second, I think you're -- there's a lot of what you've said that I agree with, but I think you're drawing a distinction between salary and other forms of income that I'm not sure I agree with.

CHAIR ROSENBAUM: No, and I didn't mean to.

COMMISSIONER THOMPSON: Okay.

CHAIR ROSENBAUM: It is are you -- the word is "compensated." Are you compensated? Whether it's salary, whether it's a consultancy, is your compensation derived in some way from an entity that does business with Medicaid?

COMMISSIONER THOMPSON: I guess I would just say that I think that in general, appreciating that MACPAC is composed of stakeholders and representatives and individuals with direct experience with the program and direct interaction in various ways with the program, the requirements for disclosure I would think should be fairly low while the requirements around recusal should be fairly high. And in recusing that -- that issue of -- I assume that the issue of the specificity of the impact and the size of the impact would be critical to determining whether or not recusal would be merited or not.

COMMISSIONER RETCHIN: First, let me just say I think that the policy as framed is a good one, and I think it does meet Senator Hatch's requirements -- rather, suggestions. I will say the other extreme, however, in terms of recusal from discussion I found to be particularly onerous. But let me just sort of draw this out the way I see it. I think the tension here is are we -- and it really is the entire structure of the Commission. Are we regarded as stakeholders or are we regarded as experts? I think those are very different and actually have self-fulfilling prophecies on the former. That is, if we're regarded as stakeholders, then we will always have a very homogeneous viewpoint. We'll never get heterogeneity at the table for a rich and robust discussion. In my view, like Penny, I think that the criteria for recusal must be a very direct and specific benefit.

Let me just point out on number 3, I guess where I was getting lost, I thought that the conflict was on an individual basis, not the conflict -- so even a single institution. I thought the conflict was on the individual, not on an entity or an institution. So if I carried that -- sometimes it's, I think, illuminating if you carry it to

the extreme. So what would be so egregious that would be a conflict? And since we're talking about DSH hospitals, I'll -- let's just put it on the table. I think it would be egregious if in my performance incentive there was a bonus that I got if DSH payments went up. It can't be a conflict for me to participate in the discussion and look at DSH policy simply because I'm the CEO of a medical center that is a high DSH hospital. If that's true, then I know there are three executives here from MCOs who will never talk about managed care policies.

So I think that that is a self-fulfilling prophecy that absolutely ignores the entire reason you have a citizen body that I'll emphasize once again -- everybody has done this -- is advisory. If we made and implemented policy -- or laws, rather, statutes governing Medicaid, different story. I don't think I can run for Congress and be CEO of -- and I'm not announcing.

[Laughter.]

COMMISSIONER RETCHIN: Anyway.

COMMISSIONER WEIL: I want to align myself with Sheldon's comments, the first part. I came at it from a slightly different direction, and I think, Sara, this is an

instance where I do think I see it a little differently than you do. And I'm a little worried then that, Mark, you joined in.

It's risky always to put yourself in the position of thinking what Congress meant, but when I look at the list of the different interests to be included in MACPAC, I see that as viewpoint diversity, not as giving us a pass on financial conflict. And so I think it's risky to say that because they wanted a variety of viewpoints, they therefore and we shouldn't be worried about the potential of specific financial conflicts.

So I'd like to keep those separate and say the diversity of -- or the composition of the Commission is to assure viewpoint diversity, but that does not excuse us from having whatever we think the right standards are on financial conflicts. I see that as -- and that also I think is the response to, if I remember right, the fourth concern raised by committee staff that viewpoint diversity has to exist to have deliberation, and so whatever concerns you might have a vote on the record, if you exclude viewpoints from deliberation, then you really have undercut the statute. So I think that's the response to that group.

I am struggling to follow the -- I think I'm pretty good at the logic, but I am struggling to follow the logic and where in our actual work a principle like the effect is on a class would ever show up, because if I'm reading right, clearly a DSH hospital employee does have a reportable interest that triggers COIC review. I don't see how we get out of that. But then COIC shall determine the appropriate response, and there's no guidance, if I get it right, for how they should respond. And so the notion that they should permit the conflict to exist if it is only with respect to a class is absent from the document.

So that's what I'm having trouble with, is that it seems that we've put more of the attention in the policy on what triggers review than we have on what to do about it if the review exists. And so I'm sort of -- sorry, but I'm back to my first question, which I think by jumping to try to answer the DSH scenario, didn't quite get answered, which is: Is this level of looseness with respect to determining the appropriate response typical? Or do we need at this stage or through some future document to put down and debate in public whether a policy that affects a class, even though it fits the definition of what should be

reviewed, that the COIC shall not in that instance recommend recusal because it is with respect to a class?

And I'm going to do a 30-second shift on this scenario, which is it's fine to talk about eliminating DSH, but I think a more realistic situation is reallocating DSH dollars towards high DSH institutions, and if we have a member from a high DSH institution and no members from sort of low DSH, if you will, that to me seems like a more realistic situation where the question of conflict comes up.

CHAIR ROSENBAUM: Yes, and that's why I noted before that the -- I went right to, as this issue of specific versus class as my concerns about the statute versus our process and our policy have bubbled up together, Chuck, that this -- that where my eye has come immediately is, as I say, page 5, lines 14 through 19, because I think we need to -- and I want to get us through the last part of the discussion. We have one remaining question from Congressmen Pitts and Upton's staff that I want to be sure we don't drop the ball on. But this is where we need to sharpen 3 in order to give the public, I think, a greater insight as to what separates what may be a conflict from

what is not a conflict, okay? Because unless it's a conflict or appears to be a conflict, there's no recusal question at all. And that I think we keep circling back to these five lines.

So let's put a pin in this, and I've got Marsha, Chuck, Toby.

COMMISSIONER DOUGLAS: Can I just to make sure --

CHAIR ROSENBAUM: Yes. Yes.

COMMISSIONER DOUGLAS: It is not just -- I mean, it would need to --

CHAIR ROSENBAUM: No. There are other places where it shows up.

COMMISSIONER DOUGLAS: And No. 1 too.

CHAIR ROSENBAUM: Yeah, yeah.

COMMISSIONER DOUGLAS: Okay.

VICE CHAIR GOLD: Yeah. I think that's good, Sara. I think this has been a really good discussion, and there's obviously been a lot of really good work here, and I was pleased to see most of the people who looked at this ahead of time thought that it reflected a fair amount of work.

My concern -- I'm a researcher, and I worked a

lot at implementation, and the clearest lesson in implementation is always it takes longer. It's more expensive and harder. And we've already seen that in just coming up with a policy. There's a lot of effort that we've had to put into this at the same time as we've been writing reports, which is Congress asked us to do, and given that the statute clearly wants us to be a diverse group with all these viewpoints, I'm a lot more comfortable with policies that sort of are almost self-implementing are a little bit clearer.

And so I think the more specificity -- or it's easier to have a recusal if we understand what's missing, and my concern is just I'd hate for us to have gone through all this work to then just have to go through more work endlessly debating what's appropriate. The only ones who win on that I think are the lawyers or the budget goes. I don't mean that you're doing it that way, but, I mean, it gets expensive, and it takes a lot of our time. This committee is going to take time. So the more specificity we could have, I'd feel a lot more comfortable.

CHAIR ROSENBAUM: Well, there is no question that the development of this policy took considerable time and

effort. The refinement of it will take time and effort, and the implementation of the policy by the Chair, i.e., me, and my colleagues who come onto the Conflict of Interest Committee is going to take real time. So time is not an infinite thing, so it means time that is not spent on other matters.

Chuck?

COMMISSIONER MILLIGAN: I was going to try to help us pivot in the direction of trying to capture this discussion and move toward a vote, so if that's okay?

CHAIR ROSENBAUM: Oh, sure. We do have one thing before we vote, one lingering question, and then we can come back.

COMMISSIONER MILLIGAN: Well, I think it's been a great discussion, and I think going back, Sara, to where you've pointed us, both page 5, lines 14 and 19, and then as Toby noted, it's in No. 1 as well, I think -- so I just want to conceptually and not -- and we don't have time to wordsmith. I think, conceptually, to me, the part -- when I look at that list in line 17 on page 5, directly, predictably, and significantly, and similarly, pages 4 and 5, lines 34 and 1, to me what is missing is perhaps the

word "particularly" or something that -- and since we're fond of footnotes in this particular structure of this document, "particularly" could be defined to mean if it's a class interest, it's not particularly or some version of that.

But I think "directly," "predictively," "significantly," and "particularly," and then to define as a footnote, perhaps particularly, it does not exist if a class is affected, I think -- and a lot of the rest of it is going to need to be done in the procedures. The policy isn't the place to get to the operations or the implementation and to define what we mean by that, but I think that or some version of that is what is missing that we're all searching for.

CHAIR ROSENBAUM: Yes. I think that's exactly right.

I have thought about whether in fact in the definitional section right up front, we define "directly," "predictively," and "significantly" for wherever it appears because it appears several times. But whether we do it definitionally, whether we do it in a footnote, whether we do it in a modification of the sentence itself, it's

customary in a document like this to do it in a definitional section or in a footnoted section.

It's dealing with what I think is this crucial issue that's come out that's been driven by both the meaning of interest here and by the statute itself, so I think that's a really good suggestion to work with.

Yes, Toby.

COMMISSIONER DOUGLAS: If it's okay if I can switch on the litigation one?

CHAIR ROSENBAUM: Yes, that would be great. That is a lingering issue.

COMMISSIONER DOUGLAS: Okay. So the question on the litigation, thinking where I stood before in terms of being a Medicaid director, was sued many times by providers and at the same time also would appeal and maybe sue CMS. And the question is where does that fit into it, and would that be not allowed, or if you're -- again, where I stand now as a health plan having to deal with rates and litigation -- and I'm sure the same if you're a provider, so where do all those fit into this?

MR. BORRELIZ: Well, the way we have written it, it's extremely narrow by virtue of restricting it to

litigation involving a house of Congress. If you have litigation involving CMS or Health and Human Services, yeah, that is not prohibited. That is something you could move toward.

COMMISSIONER COHEN: Is it okay if I jump in here?

COMMISSIONER DOUGLAS: Yes.

COMMISSIONER COHEN: Actually, as a former Justice Department lawyer, lots of cases start with named defendants that are -- you know, that cover the universe and including potentially a body of Congress, and they get dropped quite quickly. But when they're named, as somebody said, they don't really bother to drop them out. You could actually -- without a little definitional work here, you could end up actually affecting cases where really the litigation isn't about Congress, but they are a named party.

CHAIR ROSENBAUM: But it is our intention, just to be clear. Two things are our intention. One is that there is a very, very specific and narrow type of situation that would be a prohibited activity going forward, and --

COMMISSIONER COHEN: I'm just saying I think we

might need to tighten it a tiny bit.

CHAIR ROSENBAUM: We could sharpen it up, but I also want to be clear that as drafted, all of the -- what I would call sort of -- and I mean this not in a true business sense, but the business of Medicaid, which as a large program involves inevitably litigation, is not captured here in the normal course of business sense.

So the kinds of cases that health plans might bring, the kinds of cases that a Medicaid agency itself might bring against the Department of Health and Human Services is not involved, and of course, often a Medicaid agency head is the named defendant, but is not your full-time job to litigate.

So to the extent that one of the questions we received was should there just be an exception for people whose full-time job is to litigate, the answer is, well, no, because that really doesn't describe anybody. I mean, that's not the nature of this.

The nature of this is -- I think Mark put it the best -- is given the specific duty of loyalty that's involved, that to refrain from a very, very unique kind of case -- and we can clarify that, what are the attributes of

such a unique kind of case -- falls into an area that just like being a political person, being a member of a campaign, we don't want Commissioners to engage in.

But other than that, litigation is -- as I think this is true for those of us who are lawyers -- very much a point of view. I mean, it's a viewpoint. It's just a viewpoint stated in a forum that is not a congressional forum or a regulatory forum, and we are not intending to get at that.

EXECUTIVE DIRECTOR SCHWARTZ: I just want to remind people that with this new GAO form that's been added, if you are involved in litigation, you would report it as an activity of yours. It's not disqualifying, but in the spirit of transparency, in evaluating the actions of the Commission or the actions of particular Commissioners, that kind of information would be available.

CHAIR ROSENBAUM: Absolutely.

We are, I think, moving toward a vote, but I want to stop and see if there is any member of the public who would like to comment on the draft.

COMMISSIONER COHEN: Sara, are we voting on the policy --

CHAIR ROSENBAUM: I am about to state.

COMMISSIONER COHEN: Okay.

CHAIR ROSENBAUM: I am about to state what we are going to vote on. Absolutely.

So I think what we are about to vote on is the draft policy, as presented to us, with the following changes, one being a clarification along -- in conformance with this discussion of what we mean by "directly," "particularly," and "significantly." And the clarifications that are needed are clarifications related to this distinction between a highly particularized interest, again, what is referred to in law often as concrete and particularized versus a general interest in the issue as a member of an affected broad class. So that's the crucial point, and it's a point that absolutely must be clarified for the reasons we also talked about, which is that the statute itself imagines that many people on the Commission may have compensation that in some way connects back to Medicaid. So we can't end up with a definition that puts us crosswise with the statute. That's number one.

Number two, Chuck's point, which will not be in

this document but will be a separate statement of operational principles, making clear that disclosures to third parties who themselves are interested people is conduct that no Commissioner should engage in.

And the last point goes to Andy's request for some additional clarification around the one type of prohibited litigation activity, which is the activity in which either house of Congress is literally a named party in the litigation, which I should note is an extremely unusual event. But to the extent that we need to make clear and maybe offer an example or two in an accompanying note, we will do so.

So, with those three modifications, that's my proposal.

Alan?

COMMISSIONER WEIL: So I'd like to offer a friendly amendment. Knowing that we're not wordsmithing, but I feel structure sends a really strong signal. To effectuate those things, I think it would be really helpful if footnotes 2 and 3 on pages 4 and 5 were moved into the text under the B header, not in the definitions, because they're specific to the criteria for COIC review. I'm just

trying to make it the logic here. So reportable interests, the two footnotes which explicate "directly" and "predictably," which appear in bullets 1, 2, 3, and 4, instead of them seeming like small footnotes, this is the heart of B. This is what triggers review.

I would then propose -- I feel like I am beating this drum over and over. I don't know if anyone is listening or wants to. I would recommend that on page 5, under C where it says the COIC shall determine the appropriate response, that some sentence be added that reads something like, "In determining its response, the COIC shall consider the degree to which the recommendation affects a specific entity, a class of entities, or the Medicaid program as a whole." So it ties the two together. So this is what triggers review. This is what the committee should think about when it determines the appropriate response.

CHAIR ROSENBAUM: So the standard of review, you want a standard of review or a guiding principle.

COMMISSIONER WEIL: Right. I want considerations. I don't think we want to call it a standard. It's these are what they should be thinking of.

CHAIR ROSENBAUM: Sure.

COMMISSIONER WEIL: I hope that's a friendly amendment.

CHAIR ROSENBAUM: I think that's great.

So, with all of this, which I am afraid to try and summarize once more -- but I think this has been a wonderful discussion. I think we have gotten at all of the issues that are really important, both in the policy and the implementation of the policy, and so with this discussion and understanding that we will then work on drafting a follow-up policy that reflects all of this, can I ask how many Commissioners support the policy as amended?

Yes. Now we need to take a recorded vote.

EXECUTIVE DIRECTOR SCHWARTZ: So the vote is on adoption of the draft policy with the changes that Sara has articulated, so a yes vote is for adoption.

Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sharon Carte?

COMMISSIONER CARTE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Andrea Cohen?

COMMISSIONER COHEN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Gustavo Cruz?

COMMISSIONER CRUZ: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Marsha Gold?

VICE CHAIR GOLD: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Christopher Gorton?

COMMISSIONER GORTON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Herman Gray?

COMMISSIONER GRAY: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

COMMISSIONER LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?

COMMISSIONER MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

COMMISSIONER RETCHIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Norma Martínez Rogers?

COMMISSIONER ROGERS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Penny Thompson?

COMMISSIONER THOMPSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Alan Weil?

COMMISSIONER WEIL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sara Rosenbaum?

CHAIR ROSENBAUM: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. That's 17, yes.

CHAIR ROSENBAUM: All right. Well, well done, everybody. Thank you to Kate and Mark.

And why don't we take a two-minute break and resume at 11:10.

* [Recess.]

CHAIR ROSENBAUM: Okay. We are at the one-minute warning.

[Pause.]

CHAIR ROSENBAUM: All right. So I think we're ready now to resume, back to our normal programming, and first up is Moira and the new Medicaid managed care rule.

BRIEFING ON FINAL MANAGED CARE RULE

* MS. FORBES: Sure. Thanks, Sara.

So on May 6th, CMS released the final Medicaid managed care rule which modernizes the regulations to reflect the significant changes in the use of Medicaid managed care over the past 10, 15 years. This is the final version of the draft regulation that came out last spring and which the Commission discussed then. The effective date of the final rule is July 5th, although some of the new provisions will be phased in over the next several years.

In this presentation, I'll provide some quick background on Medicaid managed care and remind you about the Commission's comments on the draft rule. I'll walk through some of the significant provisions of the final rule, and I'll describe some of the work we have planned in this area.

So while states have operated Medicaid managed care programs for over 30 years, the federal rules governing managed care have only been in place for about 15 years, and they haven't been significantly amended since 2001.

Last spring, CMS published a Notice of Proposed Rulemaking to modernize the rule. During the 60-day

comment period, CMS received almost 900 comments from state Medicaid agencies, advocacy groups, health care providers, managed care plans, trade associations, the general public, and MACPAC. The comments ranged from general support or opposition to the proposed provisions to very specific questions and comments regarding the proposed changes.

MACPAC submitted generally supportive comments on the proposed rule and included two specific recommendations.

First, the Commission suggested that CMS consider the importance of adequate resources for implementation and operations. The comments emphasized that the implementation of the new rule should be carefully staged and adequately resourced.

Second, the Commission addressed the proposed medical loss ratio provision and expressed support for a consistent national method for calculating a medical loss ratio but encouraged CMS to carefully consider which aspects of the Medicare managed care delivery system are sufficiently different from other managed care programs to require a Medicaid-specific definition or approach.

Many other commenters offered similar suggestions

regarding both the implementation timeline and the medical loss ratio provisions, although some commenters also suggested alternatives. Both of MACPAC's recommendations were adopted by CMS.

Regarding the implementation rollout, the final rule approaches implementation very thoughtfully. While some of the provisions of the final rule go into effect either immediately or when the rule goes into effect on July 5th, many of the provisions that affect health plan contracts will not go into effect until the contracts that take place on July 1 of next year. So states and plans have a year to develop contracts that are compliant with the new rule.

Many of the provisions that require states or CMS or the health plans to develop new standards or processes, for example, the network adequacy standards or the new provider screen and enroll requirements, those won't go into effect for two years. And some requirements, such as the quality rating system, will be phased in over even longer periods to allow for public comment and collaboration between CMS and the states.

In terms of the medical loss ratio, which the

Commission commented on, this is one of the many areas in the regulation where CMS sought to balance consistency among the rules that apply to different programs--between Medicaid, Medicare Advantage, private health plans--with the differences in Medicaid, who and what is covered by Medicaid, how Medicaid health plans are contracted, overseen, and paid for.

The medical loss ratio provisions in the final rule use the same general calculation methods used by other programs, but CMS pointed out that it will take into account during the rate review the fact that activities encompassed in various categories, you know, may be more intensive and costly for Medicaid health plans due to the unique characteristics of the Medicaid program.

So I'm going to walk through about a dozen of the significant provisions in the rule. Of course, the final regulation touches on, you know, every aspect of Medicaid managed care. It's an enormous rulemaking.

CMS has issued several detailed fact sheets. There's a lot of additional material coming out about this. We are, of course, monitoring this, and as more information comes out, you know, we can share that with you.

So payment and rate setting is a very significant part of the new rulemaking. It's the first set of issues that CMS addresses in the preamble to the new regulation. It actually covers maybe 100 pages of the preamble, and it's obviously an issue of very significant interest to all the stakeholders affected by the rule.

The rule provides a lot more detail on the steps a state, acting through its actuary, must follow when establishing Medicaid managed care capitation rates starting in 2017.

The rule puts more explicit bounds around what states are allowed to do, but it also provides some specific areas of flexibility. CMS spent a lot of time summarizing the comments it received and explaining its rationale for what it decided to put in the rule, where it differed from what it had proposed, where it made changes from its current practice, and where it landed where it did in terms of what's allowed and what's not allowed.

A few specific things. States are no longer allowed to submit a rate range. That's the practice in some states now. They must submit a specific rate for each rate cell. But what is different from what was proposed is

that states are allowed to make changes within a narrow band without needing reapproval from CMS.

There were a lot of comments from states around the process for this. There's a lot of concern about how much flexibility states have to make changes and around how much -- what kind of constraints there would be on the ability of states to sort of manage the ongoing sort of day-to-day operations of their program. In the natural course of doing business, things come up, and states were concerned about the extent to which this rule would complicate their efforts to manage their programs. And so CMS, in going from the proposed rule to the final rule, clearly put effort into trying to find that balance between federal oversight and state flexibility to operate programs.

Some other changes. States can specify in their contracts that managed care plans must adopt value-based purchasing models for provider reimbursement. States can make that a requirement of managed care contracting, participation in specific types of models. They can allow states -- or, sorry, states can specify minimum provider payment levels that managed care plans must use, similar to

the primary care payment bump. They can also specify maximum provider payments that managed care plans can pay.

The rule also phases out the ability of states to use pass-through payments, which is actually not technically allowed under current rules, but there's a great deal of discussion in both the proposed rule and the final rule about many states are actually still using these payments, and there will be a 10-year phaseout period of this.

There's a lot of discussion about exactly the circumstances under which pass-through payments will be allowed going forward and what will not be allowed going forward. And this is, I think, an area that the Commission should pay a lot of attention to in line with the work we've already done around supplemental payments and payment policy generally.

COMMISSIONER COHEN: Moira, can you just clarify? Can you give us two examples of a pass-through payment?

MS. FORBES: Some states make lump sum payments to hospitals, nursing facilities, or physicians through the MCOs and require the MCOs to pass those payments as lump sums to those providers. So instead of going around the

managed care plan, they go through the managed care plan.

CHAIR ROSENBAUM: So, in other words, the payment is part of the contract as opposed to a payment that happens outside of the contract, and the managed care plan essentially is administering the supplemental payment system.

MS. FORBES: And the actuarial soundness rules in theory prohibit that as an actuarially sound capitation rate is supposed to be sufficient to cover the services under the contract and, therefore, it sort of excludes supplemental payments.

COMMISSIONER COHEN: And is it right to say -- I'm sorry for the interruption, but I just want to understand it.

CHAIR ROSENBAUM: Why don't we --

COMMISSIONER COHEN: It's a fairly common practice today?

MS. FORBES: It is not --

CHAIR ROSENBAUM: I think we have a lot of questions about this, so why don't we let Moira get through the presentation, and then we will delve in, because I saw a number of hands go up, actually.

MS. FORBES: Sure. Part of the payment provisions is putting into regulation the longstanding guidance CMS has had regarding when and which services may be covered in lieu of state plan services. So states can authorize health plans to offer services in lieu of covered state plan services that are part of the contract and part of the capitation rate if the alternative services are medically appropriate and a cost-effective substitute for the covered service or setting, if the approved in lieu of services are authorized and identified in a contract and offered at the plan's discretion, and if they were taken into account when developing the capitation rates. It's all very optional. States are not required to offer plans this option in the contract. If it's offered, plans are not required to offer in lieu of services. If they offer them, enrollees cannot be required to use them. But this is something that is a feature of managed care that many states and health plans have actually taken advantage of over the years, and, again, it's being formalized in guidance. It's effective immediately because it reflects current practice.

The most significant application of this policy

I'll talk about on the next slide, which is its application to the Institutions for Mental Diseases coverage. This is a new policy first articulated in the draft rule last year where CMS has said that under the longstanding policy that managed care plans have the flexibility to offer alternative services in lieu of covered services under the criteria just described, short-term services provided to enrollees aged 21 to 64 in an Institution for Mental Disease, IMD, which otherwise cannot be paid for under Medicaid can be provided as alternative services by health plans. Because the in lieu of services policy is effective immediately, this interpretation is also effective immediately, although CMS and states need to work out some details around capitation rates and so on.

CMS received a lot of comments on this, which are summarized in the preamble to the final rule. They did receive some comments suggesting that they drop the IMD exclusion entirely, which is outside of the scope of this rule and would require a separate statutory change. They also received some comments questioning their authority to do this, but what they included in the final rule is largely what they had included in the proposed rule.

As I mentioned earlier, the final rule includes a requirement around a medical loss ratio. Rates must be set so that each plan is projected to meet at least an 85 percent medical loss ratio. Failure to meet that medical loss ratio threshold for a rating year must be taken into account in setting capitation rates for subsequent periods. These provisions won't go into effect until 2019, but plans will have to begin reporting their medical loss ratio for contracts that begin starting in 2017.

The preamble to the final rule includes a lot of detail about how states will be required to do the calculations, but there's still room for CMS to make some changes between now and 2019. I think CMS may issue more guidance around how states should handle things that aren't addressed in the rule. They got a lot of comments on things like how to handle health plans that enroll Medicare/Medicaid dual eligibles, some other situations like that, so there may be some refinements to this guidance over time. There are several years before these requirements are put in place.

The difference between the Medicaid medical loss ratio requirements and what applies in the private sector

is that there's no rebate requirement. It has to be factored into rate setting, but there's no requirement that anything in excess of 85 percent be returned to the state.

The final rule, in terms of managed long-term services and supports, the final rule codifies much of the sub-regulatory guidance that CMS issued in 2013 and has been applying to its review and oversight of those plans for several years, so there aren't a lot of changes. This is how states have been operating these programs for several years at this point. It's just being formally put into regulation.

There are some significant new requirements around network adequacy. By July 1, 2018, states must develop and implement time and distance standards for several specific provider types and for managed long-term services and supports programs. The final rule includes some changes from the proposed rule, including more clarity around where separate adult and pediatric standards are required. However, CMS declined to issue federal quantitative network standards despite receiving many comments requesting that they do so.

They also did not include specific requirements

about some other provider types that they had comments asking about, including federally qualified health centers and other safety net providers. And they also did not address telemedicine, although they received a lot of comments about that.

The final rule also contains many more provisions about oversight of networks, including a requirement that plans must certify the adequacy of their networks on an annual basis, and external quality review organizations need to review network adequacy as part of that periodic review.

The final rule requires plans to implement additional program integrity procedures. The GAO, MACPAC, and others have noted in the past that there's been little guidance and few requirements around program integrity for Medicaid managed care, and this rule starts to close that gap.

It also addresses a concern that the OIG and others have raised which is how to treat overpayments recovered by health plans. The final rule requires that state rate-setting processes take into account overpayments recovered by managed care plans.

Finally, the rule introduces a new requirement for managed care that brings the managed care requirements in line with the requirement for fee-for-service. In 2011, new rules went into effect requiring all fee-for-service providers to be assessed for risk and then screened appropriately, but that rule excluded managed care providers from the screen and enroll process. This rule requires that by July 1, 2018, all providers contracted with managed care plans now must be screened and enrolled and then periodically revalidated just as they are in fee-for-service. It's not a requirement that they participate in fee-for-service. It's a requirement that they be screened akin to the fee-for-service process.

Another area where the rule aligns managed care with fee-for-service and makes changes to the managed care rule to account for statutory changes that have gone into effect since 2001 is prescription drugs. The ACA added Medicaid managed care drug claims to the mandatory Medicaid drug rebate program following the longstanding rebate provisions that applied to fee-for-service Medicaid. And as you may recall, part of the rebate provisions in fee-for-service is a requirement that if the manufacturer has a

rebate agreement, the state must cover that manufacturer's drugs. So the final rule clarifies now that the rebate requirements apply to Medicaid managed care, the coverage rules do as well. When a managed care plan provides Medicaid drug coverage, it must provide coverage under the same terms as the state. It must cover all medically necessary drugs even if they're not included on the plan's formulary.

Aren't you glad I'm only doing a subset of the --

[Laughter.]

MS. FORBES: I'm getting there. We did go through the rule because the Commission has an interest in dually eligible beneficiaries. Katie did go through and looked specifically for provisions that affect that group. There are a few provisions that directly affect them. Health plans in some states will now be required to participate in an automated crossover process. That's just an administrative thing.

Some sections of the final rule, which I'll get to in a second, align the procedural aspects of the appeals and grievances process between Medicaid managed care and Medicare Advantage, which creates consistency across the

programs. It doesn't integrate the processes, but at least allows for more consistency. And other sections of the rule we did see have drawn on the lessons of the Financial Alignment Initiative of the duals demos. The care coordination sections have incorporated some of the practices that have been developed as part of those demos, so they've been using the experience at least of those.

The final rule includes several new requirements related to quality. CMS did not finalize the proposed requirement that states develop a statewide quality strategy that encompasses both fee-for-service and managed care, although there was support for that from both advocates and health plans.

The final rule does require a quality rating system similar to that used in the exchanges that will allow public reporting and comparison of health plans. CMS plans to start a public engagement process to develop this quality rating system framework and will seek to align with the indicators used in the exchange quality rating system. It's unclear exactly what this will look like at this point. And then states will have three years to implement it once the requirements have been published. This is a

long-term initiative that they're describing.

Other quality provisions of the final rule include extending the managed care quality strategy and external quality review requirements to managed care models that are partial risk or primary care -- the enhanced primary care case management model. They've also added health care disparities and long-term services and supports to the topics that states need to address in their quality strategy.

As I mentioned, the final rule makes significant changes to the definitions and time frames for appeals and grievances, to bring the Medicaid processes into alignment with the private market, and with Medicare Advantage beginning in July 2017.

Part of this alignment is a change that requires enrollees to go through one level of internal health plan appeal before they can proceed to a state fair hearing. They cannot go directly to a state fair hearing, as they can now.

There is also an explicit requirement that if a health plan makes a denial based on a lack of medical necessity, then the plan has to disclose its medical

necessity criteria and explain how the criteria were applied.

The final rule requires that by July 2018, states have to provide an independent beneficiary support system to provide enrollment choice counseling. They have to have an independent enrollment broker. That's something that most states have now but not all states, and not all states have it for all programs. They may have it for sort of a regular managed care program, but not for the managed long-term services supports program. But they need to have it for any managed care program that they operate.

The final rule does not include the proposed provision that states would have to cover beneficiaries and fee-for-service for 14 days prior to being assigned to a managed care plan. This proposal drew significant pushback from states and plans.

The final rule also makes numerous changes to the enrollment information and communication requirements to approve content and distribution methods in recognition of the many ways in which people communicate with providers and health plans outside of the U.S. mail. Like, health plans can text people. Now that's allowed, which is, I

think, a big improvement.

And finally, because an overall goal of the rule is to align CHIP exchange and Medicaid standards where practical, in many places the final rules for Medicaid are also applied to CHIP.

In terms of the next steps for us, we have several different things going on. CMS recently released its 2014 Medicaid managed care enrollment and program characteristics report, and staff are in the process of updating the MACSTATS managed care enrollment table. And we're conducting additional analyses of managed care enrollment and spending trends and updating all of those tables that we produced.

This month, we just kicked off a new project focusing on program integrity and managed care, which has been an area of longstanding interest to the Commission, but it's something that we didn't want to start in absence of the rule. So now we've finally been able to get that going.

We're also starting some new work around managed long-term services and supports.

Going forward, we'll continue to assess the

effect of the final rule on areas that we know are of interest to you, including behavioral health, access to care, payment policy, and delivery system reform, and given your stated of concerns regarding the adequacy of state and federal resources to fully implement the new rules, of course, we'll be monitoring the rollout of these provisions over the next several years.

We are updating the regulatory index on our website. We have a detailed point-by-point index. We're putting in all the new citations so that it will be current when the final rule goes into effect in July, and we're producing a new set of issue briefs for publication on the MACPAC website.

As you may recall, the second MACPAC report in June 2011 focused exclusively in managed care. It has not been updated, so we are going to produce a set of issue briefs on those topics: populations and enrollment, plans, payment policy, access, quality, accountability, integrity, data. And we'll update them in the context of the final regulation, new policy developments, and other research that has come out over the last five years.

So some of the things that we will be adding to

that will be things like the duals demos, mental health parity, value-based purchasing, managed long-term services supports, and so on. So we're certainly interested in anything the Commissioners have to suggest around other things we should be thinking about as we're now finally going to do some work on managed care.

CHAIR ROSENBAUM: Great. Thank you.

So now I have Andy, who started the line of questioning, and who else do I have? Toby, Penny, Brian. Okay. Take it away, Andy.

COMMISSIONER COHEN: So it is really just sort of clarification about the passthrough payments that are prohibited. Are they supplemental? Are you specifically talking about supplemental payments like DSH and UPL? Because I have certainly heard of number of passthrough payments that wouldn't raise an eyebrow or at least did not raise mine as sort of in any way problematic, that were very much related to sort of policy goals or otherwise. So I was just trying to really understand what the goal of that part of the regulation was and its scope.

MS. FORBES: Sure. We have not gone into detail on this, and what's in the final rule is slightly

different. They did come back and change a little bit, partly because I think CMS learned more since the proposed rule about the extent to which these were being used.

But, yes, the general understanding since 2001 is that things such as UPL supplemental payments are prohibited, given the actuarial rule, but they are in use in some states, and so those states are being given 10 years to phase those out of the rate-setting process.

COMMISSIONER COHEN: Okay. But the concern is really around those kinds of supplemental payments?

MS. FORBES: Yes.

COMMISSIONER COHEN: Okay.

CHAIR ROSENBAUM: I do have to say it raises an interesting question to me that I had never really thought hard about, which is under the statute, a managed care organization obviously exists to administer medical assistance program for states and to do so under certain payment structures. But the managed care organization has this interesting sort of third-party administrator dimension to the Medicaid program, and so it is not -- it was not immediately apparent to me why a managed care organization, as a legal matter, cannot take on certain

responsibilities that are subject to the actuarial value and MLR requirements and other responsibilities for a state that have to do with third-party administration of various elements of the program.

And I should note that one of the ways that that has manifested itself -- and it's been sort of a significant issue for a number of states -- is where you have certain providers that by law get supplemental -- not supplemental payments, but have to be paid at a certain rate. Can the managed care entity administer the rate-setting mechanism? And that has resulted in sort of a separate set of questions.

So this issue is not only in the managed care -- in the supplemental payment context. It comes up generally.

COMMISSIONER THOMPSON: Well, if I could just comment on that, I think the regulation is trying to address a problem about payment as opposed to administration, which is the idea, and there has been kind of longstanding policy and practice around this, that if you are receiving a capitation payment and that capitation payment is actuarially sound, which means it reflects the

cost necessary to deliver the benefits and services at rates that provide the access that are required by the statute, then any other payment would be duplicative in nature. And duplicate payments are prohibited.

So, on the other hand, obviously there are states that administer supplemental payment programs, and to the extent that they value those and wanted to retain those, they may have been dissuaded from moving to a fully managed system because to do so would prohibit them from maintaining those systems. So I think what the rule is trying to do is kind of bring those worlds together and to say we certainly don't want you to not engage in a service delivery reform that you think is beneficial to beneficiaries, but it doesn't coexist easily with these supplemental programs. And so we will have to monitor them and transition those out over time.

It does raise lots of questions, and I think that those questions ought to be engaged by the Commission because I think it's related to other things that we've been discussing and working on over time.

CHAIR ROSENBAUM: It is terribly important to me. The example that came to mind right away, which I think is

dealt with in the rule, is GME. So there are certain teaching entities that get GME payments, which one would think would really not be bound up in the question of is this an actuarially sound payment for services, although to some degree, it might be. But there's the separate question of what's GME payment.

So I think that this question of teasing apart the use of third-party administration to deal with parts of Medicaid that exist outside of what might be put into an actuarial value-tied rate, but then the question of what's an actuarially sound rate, it seems to me that we have sort of two different dynamics going on.

COMMISSIONER THOMPSON: I might put it a little bit differently. I think it's an issue of the program might be spending money in various ways for various things and outside of what a capitation payment is representing in that context, and then the question is, What is that spending for? What is it about? How much does that vary by state? What's the level of spending associated with those purposes? And that spending might be taking place around a bunch of different designated and non-designated at the federal- and state-level programs.

CHAIR ROSENBAUM: I have Toby, Brian, Chuck.

COMMISSIONER DOUGLAS: So, first off, it's a really good analysis and really helpful.

A couple comments, first, around just from a state perspective, this enormity of these rules, when I think of it back in my state days, it's going to be a lot of work on states to try to implement, and we definitely have to keep on looking at that.

One in particular is going to be really concerning both from a state and the plan is just the provider enrollment rule, and I think we're going to need to track that, both from an access standpoint on the implications of a lot of providers who never wanted to deal with the fee-for-service and what it means to go through, in most cases, most states, a very cumbersome process, and how does that impact on access? The question of sophistication of the states on dealing with the qualities and implementing those is going to be hard.

Now, on the supplemental payment -- so this is where I want to add to this discussion -- I would start with I definitely beg to differ on the question of whether it's allowed currently. They are allowed under the current

rules, which is why they've been going, and I think it's a little bit of a -- or it is a mischaracterization to say they are not actuarially sound.

The actuaries -- and we've got Stacey over here. Maybe she can -- you know, they're certified within the rate. Those supplemental payments are part of the actuarial soundness and determining whether it is. They are targeted supplements to inpatient, to outpatient, to sets of providers, and that's where the rub is, around the ability to create the separate lump-sum payment that has been actuarially certified, where then a plan gets, and behind the scenes, smoke and mirrors, are going to different providers. And unwinding that does have significant implications on questions of access and being able -- and what Penny said. The reason many states were able to move to managed care and to this system was built on trying to take components of a system that paid providers differently in fee-for-service.

We have that rub with a value-based system that we're now trying to implement, which CMS is saying, "Okay, you can do this, but only within value," or, "You can do this only if you pay all providers the same set rate." And

that might be the right approach, but it's something we're going to have to carefully assess as it relates to access, to ability, to maintain these delivery systems the way they are, and how it happens over time.

CHAIR ROSENBAUM: Thank you.

Brian?

COMMISSIONER BURWELL: So I have questions, and they relate to this last slide. My questions have to do with, What role do the Commission and Commission members have in these various activities? What role do we have in helping to specify the scope of the managed care analyses, what you're going to do, the scope of these new projects, to have input on assessing the effect of the federal -- I mean, what is -- how do you see that playing out as for the Commission?

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. We will be sharing with you some more information on research contracting.

I would just say, in short, the ideas for research contracts come from a variety of sources, Commissioners being an important part of that, and I would say to the extent that you have ideas about specific policy

questions that could be -- that need exploration or data analysis or information gathering, that would be helpful.

These two particular projects, the one on program integrity and the one on MLTSS, which is going to be looking at what are network adequacy standards in MLTSS, came up through an open solicitation we did to our contractors, and we said, "Here's the areas we're working in. Send us a letter of intent if you have a good idea," and I would guess that most of them are related to other things that those contractors are already doing. And we winnowed those down based on sort of relevance to other work that the Commission is doing, scope, what we can afford, and whether we actually thought that it would give us some information that would be useful too. And so that's the genesis of these sorts of projects.

But, certainly now, later, during other sessions today, if you have an idea for wouldn't it be great if we could have some information that would fill in the blank, that can be a very useful and helpful thing to staff in starting to scope out additional projects that we would contract with, or sometimes it's analysis that we can do now.

COMMISSIONER BURWELL: Ideas are one thing, but also having input into the scope of work is a secondary. You know, here is the idea. We're going to do a study in this area. Do we ever come --

EXECUTIVE DIRECTOR SCHWARTZ: I mean, in the past -- I guess I would say the level at which is the most helpful is -- I mean, we spend a lot of time internally working on the scope of work. The specificity that you have about the idea, the gap in our information is this, and you could get it by this way. Those are things that would be helpful to us.

We have some limitations because of our size. A big research project for us is $300,000, and so that's sort of a useful thing to keep in mind. And so, traditionally, the Commissioners have been idea generators, sometimes reactors to ideas, and then the staff has carried out the actual contract process and then the program officer practice.

And then to be totally fair, sometimes we do work and we go through a whole contract, and when we get to the end, we realize we have a lot of information, but none of it is that useful in actually answering a policy question.

And some of that information, we can sometimes just, you know, share through the website or whatever, but it didn't actually illuminate the question that way we wanted to. And that's not always a function of a bad scope of work. It's just the "there" that we thought was going to be there isn't there, so both things happen.

CHAIR ROSENBAUM: All right. We have Chuck and Kit, and then I think this is just a monster of this rule. I mean, I have 91 things I've written down on my list, so I think we've got to come back to both the issues that have been raised as well as other issues, but why don't we get Chuck and Kit's questions up on the table. And then I think we need to move to the next presentation.

COMMISSIONER MILLIGAN: I'll be brief, and I'll frame it in the way of kind of future work for MACPAC.

Two points. One is about this pass through issue that a few people have talked about. I think that there is a dimension about the financing of the Medicaid program that is part of that because one of the techniques some states have done is to have things run through the MCOs for these lump sums for the purpose of generating a premium tax off of it. So there's a financing piece that is

implicated. Outside of managed care as an enterprise, it's the financing discussion.

And the second point is the process by which new Medicaid beneficiaries get enrolled in an MCO and the independence in enrollment broker, Moira, that you mentioned, how that aligns with exchange enrollment and other things, that to me, if a family is applying and some of the members of the family are exchange, some of the members of the family are Medicaid, how does this new rule align plan selection on the exchange side and the Medicaid side? Because I think it might complicate things, FQHCs and others that do counseling. So I think that we have to look at the choice counseling piece of it.

CHAIR ROSENBAUM: Yes. It is interesting this is on my list as just a central issue, and the rule expands actually. The marketing rule expands the degree to which plans can advertise that they are cross-over companies, and so it's all wrapped up in the alignment question.

Kit, why don't you finish us off on this section.

COMMISSIONER GORTON: So just building on Chuck and Toby's comments and on, Sara, your exchange with Penny, we have talked about states using these passthrough

payments to fund various things in Medicaid.

The states also, in the interest of frugality and leveraging existing infrastructure, used the plans to administer non-Medicaid activities as well, and sometimes are less than disciplined about being clear what they segregate for claiming federal match and what they don't. And that's an obvious frailty that people need to address.

But it also is, I think, an important administrative mechanism that lets the states quickly and expeditiously push money out into the world, which is vaguely health care related, but which may or may not fit under the definition of either a Medicaid state plan or a waivered service.

And in particular, where I think this crops up and where we should pay some attention to it is in the MLTSS world where, arguably, there's a whole domain of services sort of that address social determinants of wellness that don't meet anybody's standard definition of a Medicaid service. But if transitional housing is what's necessary to do, then the states can and do -- and I believe will still be permitted to -- use the plans as a vehicle for allocating funds out into the community.

CHAIR ROSENBAUM: Yes. This is one of the things on my list as well, this renewed attention on social conditions and using entities that have developed special competencies in doing more than just administering essentially the insurance plan, they are administering more, and that in turn raises issues with the in-lieu-of standard, which from the little bit I can see, I think, is being interpreted out of all balance with what was intended. That is to say that the concept of what is in lieu of goes well beyond medical care items and services that are simply not covered under the state plan, but may also get into a lot of upstream expenditures that are not connected with the concept of medical assistance.

So all of these issues become related, and of course, it all then circles back to this question of what are the limits on what the relationship can be between a managed care organization and the sponsor. So it's a very complicated set of issues that we will obviously have to come back to.

Okay. Well, thank you very much, and we have lots to think about.

So now we're ready for the simple subject of

Medicaid eligibility reviews.

ISSUES IN FORTHCOMING PROPOSED RULE ON PERM AND MEQC

* MS. FORBES: So on April 13, the Office of Management and Budget began review of a draft rule regarding changes to the Medicaid Eligibility Quality Control and the Payment Error Rate Measurement programs in response to the Affordable Care Act. That's the notice they publish on the OMB website.

Because the draft rule is being published -- is being reviewed by OMB right now, that means that we anticipate that the draft rule will be coming out soon, certainly in 2016. But if it is released between the May and the September meetings, there won't be another opportunity for the Commissioners to raise any concerns in public before commenting, so we want to highlight some of the major issues that we anticipate will be in the rule today, although we don't have an actual rule to discuss with you.

So some quick background before getting into the issues that may come up in the proposed rule. States must conduct two different types of retrospective eligibility

reviews, which are detailed reviews of eligibility cases to make sure that they are correct.

The two programs are Medicaid Eligibility Quality Control, MEQC, and Payment Error Rate Measurement, or PERM. I'll talk a minute about why there's two.

PERM, MEQC, and their relationship to the ACA are issues that the Commission has actually discussed several times before. In the June 2013 report, MACPAC used the overlap between PERM and MEQC as an example of the duplication that exists in a lot of federal program integrity programs, and in the March 2014 report, MACPAC noted that policymakers should revisit eligibility quality control, generally, given all the changes that the ACA made around eligibility processes. And I'd certainly refer you back to those chapters for all the gory details.

I would also mention that while not specifically about PERM and MEQC, MACPAC has made prior recommendations about program integrity that you might keep in mind if you are thinking about commenting. In 2012, the Commission made two recommendations, one of which is summarized on this slide. It addresses the importance of improving coordination and removing program redundancies across

federal and state program integrity initiatives. The other recommendation was around improving analytic tools.

So while MEQC and PERM and often cited as examples of redundant program integrity efforts, there are several reasons why there are two separate programs.

MEQC was created in 1978 to monitor the accuracy and timeliness of Medicaid eligibility determinations in order to avoid inappropriate payments and eligibility decision delays. All states must conduct MEQC reviews each year, although most states now conduct pilot projects and not full reviews. It was created long before CHIP and long before a lot of the eligibility simplifications. It was created before the delinking of Medicaid from cash assistance. It applies only to Medicaid.

PERM eligibility reviews were implemented in 2006 to comply with the Improper Payments Information Act, which requires an annual estimate of the amount of improper payments in federal programs. Eligibility reviews are conducted by one-third of the states each year, so each state is reviewed every third year. Because the law applies to all federal programs, both Medicaid and CHIP are reviewed in PERM.

Because of what they are designed to do--the rules for conducting MEQC and PERM, how the samples are drawn, what documentation is reviewed, what counts as an error--the rules overlap, but they don't align. They aren't exactly the same.

In addition, the ACA created many changes to eligibility processes. For example, it encourages the use of phone and online applications. It created a federal exchange that can accept and process and transfer Medicaid applications, and neither PERM nor MEQC is set up to provide good information on the accuracy of these new processes. They measure a lot of information that's not really relevant anymore, such as the timeliness of information in a paper case file, and they don't look at things that we might want to look at now, such as how well did the federal exchange hand off information to the state.

CMS has tried to align MEQC and PERM before. In 2009, Congress directed CMS to coordinate implementation and reduce redundancies. CMS developed guidance allowing states to use PERM data to satisfy MEQC requirements and vice versa, but both programs remained on the books, and states didn't find the solution to be totally satisfactory.

That's quite a euphemism.

[Laughter.]

MS. FORBES: In 2013, in recognition of the challenges states were facing in implementing all of the ACA-mandated eligibility policy and process changes from Medicaid and CHIP and the need for CMS to just update its program integrity guidance for eligibility to account for all these changes, CMS put it on hold. The implemented a 50-state program to replace MEQC and PERM for federal fiscal years 2014 through 2016, and they've -- this is a mistake -- they have extended the pilot for one additional year for FY2017.

There is not a lot of information yet on these early pilot results, but what we do know from CMS is that they have identified some vulnerabilities in the processes and systems that states are taking action to address, which is important in reducing future improper payments.

They have found instances where caseworkers and systems have not properly established household composition and income level, although this does not necessarily mean that there was an eligibility error, and finding mistakes in your underlying information does not necessarily mean

that you ended up with the wrong determination.

The pilots have also provided the states feedback on their processes as they identified issues with improper requests for additional information from applicants, failure to send appropriate notices for denied cases, and failure to appropriately transfer denied cases to the exchanges. States have been implementing corrective action strategies such as caseworker training and system fixes.

So last fall, CMS announced that it would begin using a federal contractor to conduct PERM eligibility reviews. Starting with a pilot program in one-third of the states later this year, they extended the pilot, as I said, for one year, and as part of this extension, they will be using a federal contractor in a third of the states.

The other 34 states will conduct their own reviews into the pilot program that is replacing PERM and MEQC.

The federal contractor pilot will be used to refine the federal eligibility review contractor process prior to resuming calculation of the PERM eligibility error rate in fiscal year 2018, starting in the summer of 2017.

Use of a federal contractor is similar to the

model used to measure the accuracy of claims payments in PERM. CMS has been doing that for over 10 years. They work with states, but they use a contractor to conduct the actual reviews and calculate the error rates, and this model is intended to reduce the burden on states and also help to improve the consistency of the reviews.

So while we don't know exactly what will be in the proposed rule, we expect that it will certainly address this federal contractor model. It’s a major change from how things are done now, and I think they are going to have to address that in the rule.

They are also likely to provide some clearer differentiation between PERM and MEQC to reduce overlap. It's possible it will introduce some other changes to the process to reduce state burden. If they decide to continue the model that they're introducing this fall, where they have a third of the states do PERM and the other two-thirds of the states do MEQC pilots, that can certainly reduce a lot of the state burden.

CMS may also address some of the technical aspects of the review process in the rule, but it's hard to anticipate exactly what that will look like, so it's hard

for us to imagine how we might comment on that.

As I said, we expect that the Notice of Proposed Rulemaking will be published shortly. This is an opportunity for you to raise any comments or concerns in public before commenting. If the proposed rule is released over the summer, we can certainly draft a letter based on your discussion today and circulate that for review via e-mail, but if there's any issues that you'd like to raise, I can take note of those now.

CHAIR ROSENBAUM: So questions? Comments?

Penny.

COMMISSIONER THOMPSON: Just a couple of areas that I think bear watching as CMS finalize -- or drafts this rule, one is with all measurement programs intending to aim at accuracy, there is always this counterbalance between business processes and work flows that produce accuracy and business processes and work flows that can impede access. And so one of the things that always concerns me when we talk about payment accuracy programs is we don't have other kinds of data around how long it took to apply what kind of burden was placed on the applicant in applying, but we're only looking at accuracy. We can't

easily judge the overall process because we're actually only getting one element of success from that process.

So I just think as we look at this, there are processes that can produce very good accuracy but impose a lot of time and burden on an applicant, and there are other processes that can produce potentially equally accurate outcomes, but have less burden. The latter is a preferable business and work flow to the former. So I just think that that's something that we should look at and think about, and whether or not there's any element of either PERM or MEQC that's also looking at compliance with other aspects of the applicant experience and the overall timeliness of application disposition, which is also a regulatory requirement.

And then the second point is that a lot of the new eligibility processes moved business rules and work flow from a non-automated to an automated environment. So the degree to which we can look at these rules and understand how they test whether or not automation is producing the expected outcomes as well as whether caseworker actions are producing the expected outcomes, I think is one of the things I think we can expect to see

addressed in these rules and should draw our attention, because if we're moving a lot of the process to an automated process, then it's really important that we have discipline and measurement that assesses whether those automated processes are functioning correctly or not.

CHAIR ROSENBAUM: Yes, Norma.

COMMISSIONER ROGERS: Just a quick comment based on what you were saying, Penny, is that, you know -- and I am looking at where you have casework training. The issue with casework training is that the turnover in caseworkers -- so is training continuous, consistent? You know, it's very ineffective, and it's not cost effective because it costs a lot of money to do casework training. How much money are you investing in it, especially when you have a high turnover rate?

And as automation comes and you want them trained into using that, how often are you going to be doing it?

CHAIR ROSENBAUM: Alan.

COMMISSIONER WEIL: Having not been on the Commission for any time when we've done sort of comments on rules and realizing that we don't have the rule in front of us to react to, I am going to stay way up here, probably

even further up here than Penny was, although I really agree with the comments.

When you go back to the origins of these programs, even the term of "improper payments" and the like, these are important program integrity elements, but as you note, there are errors with consequences and errors without consequence.

And in particular, in a purportedly universal coverage environment, there are also two different kinds of errors without consequence -- or I should say two different kinds of consequence for error. One is a documentation error that really doesn't change the outcome, but the other that I think is the new world we're in is errors that place people in the wrong program. But that's very different from including someone in a program inappropriately when there is no other place they would have been.

So to the extent that -- again, this is all very broad, but to me, what's important in the evolution, given that we're not looking at a rule, is whether the overall enterprise is situating the technical measurement in one program in the context of the notion that if the person isn't in this program, they probably belong in another

program that would cost the federal government a certain amount of money if they were in that program, and so the consequences of error are different.

I'm not suggesting that means we should not worry about them, but I would hope that concepts of measurement, just like Penny's notion that measuring the cost -- the consequences of an error has both negative burden, you can over -- I won't try to say it. You said it better. But similarly, the notion of an improper payment in a program, some of that implication is mitigated if appropriate determination would have made someone eligible for a different program. In fact, in some instances, as we know, you could put people in the wrong program and it could cost the federal government less, and so that's what I would be looking for is whether this represents a shift in thinking as well as the details of how it's done.

CHAIR ROSENBAUM: Stacey.

COMMISSIONER LAMPKIN: I just have a minor add. I totally agree with what you say. Just a reminder that there are a number of states out there that still have that yes-no flip, and so there is a matter of should something have been in the middle.

CHAIR ROSENBAUM: Chuck.

COMMISSIONER MILLIGAN: Yeah. I was going to piggyback that too, and it's not just within the state.

One of the issues in New Mexico right now is integrity of data if somebody who may or may not live in Texas where there isn't the Medicaid expansion is applying to benefits in New Mexico where there is, and whether that's creating payment integrity.

I am not going to -- I think it's been stated better than I would state it, but I do think that if the fundamental issue is the federal government spending money that it shouldn't, having the lowest possible administrative burden to achieve that outcome is the principle.

CHAIR ROSENBAUM: Any remaining questions or comments?

[No response.]

CHAIR ROSENBAUM: Well, we have time for public comment. Do we have anybody in the audience who would -- thank you, Moira -- who would like to make a public comment at this time?

PUBLIC COMMENT

* [No response.]

CHAIR ROSENBAUM: No? Then we stand in recess, and we will reconvene at -- what is it? One o'clock? 1:15, back at 1:15.

* [Whereupon, at 12:11 p.m., the Commission was recessed for lunch, to reconvene at 1:15 p.m., this same day.]

AFTERNOON SESSION

[1:13 p.m.]

CHAIR ROSENBAUM: All right. I think we are going to reconvene ourselves because while everything we do is important, some things are more important than other things, and this next session on the children's coverage issues -- this is behind Tab 5 in the binder -- really is incredibly important because we have to make a series of decisions today. We really -- I mean, we don't have to, but if we want to be able to make sound recommendations to Congress, we really need to make decisions today that give the staff enough sense of direction of where we want to go so that we will have what we need to make the congressional recommendations in a few months.

Of course, as always, Chris and Joanne have done a great job of, as they say, teeing up all the things we're going to have to decide. And so I'm going to turn things over to you guys so that you can start us off, and then we really will be steeped in a very important discussion for a while.

KEY COMPONENTS AND DECISION POINTS FOR THE FUTURE OF CHIP AND CHILDREN'S COVERAGE

* MS. JEE: Okay. Thank you. So the focus of today's session on children's coverage is on the key components of a future recommendations package and the key decision points for each of those components.

You'll recall that at last month's meeting -- or in the March meeting, the Commission discussed and did some narrowing down on what the components would be and considered criteria for addressing the components. The criteria are coverage, affordability, adequacy of benefits, impact on state flexibility, and federal and state spending. So that's just a quick reminder for you all.

The March discussion also underscored the importance of CHIP in providing comprehensive health coverage to children above the Medicaid eligibility levels and the importance of state flexibility in designing and operating those CHIP programs.

Commissioners, you stressed that any recommendation on children's coverage should address the shorter-term needs of reducing uncertainty around CHIP funding for the states, and for families, the availability of adequate and affordable health coverage.

You also stated that recommendations should give

states options to move forward toward a longer-term vision that integrates CHIP with other available coverage sources.

And, Commissioners, you generally seemed to coalesce around a package with multiple components to achieve those goals, and so today we're going to pick up where you left off.

The first thing we'll do is review the key components that you all identified in March and then begin to talk about those key decision points with respect to each one, and our goal today is to really walk you through systematically each of those things. And as we do that, you'll see that there are several decision points, and we acknowledge that today you might not be ready to address or speak to, you know, every single one of those. But to the extent that you can, even if it's just to take some of the things off the table, that would be helpful for staff moving forward. So following that, we will, of course, talk about our next steps.

Okay. So this slide here is just a very quick snapshot of the key components for the package that you all discussed at the last meeting. I'll just quickly list them for you now, and then like I said, we'll go through each of

them.

At the top you have extend CHIP funding, and that really is sort of the starting place for us with this recommendations package. So we'll talk about that, and then we'll talk about the four that are below that, which are sort of the add-ons, if you will, that you also could consider for inclusion in the package.

So under CHIP, we have permit optional CHIP-financed exchange subsidies, and then enhance exchange coverage above CHIP eligibility levels, broaden state innovation waivers, and then we'll just talk briefly with you about other extenders that you might consider.

So this is just the road map, and we're going to dig into each of these components.

Okay. So the first is extend CHIP, and in March, there seemed to be a general agreement among Commissioners that this funding extension was necessary, so that's why it's sort of at the top there. So what this means is CHIP funding is renewed for some specified period of time. We didn't really get into that in March. And the program would continue largely in its current form without any real changes to the structure at the federal level.

So turning to the decision points, the first is: How long should CHIP funding be renewed? Most recently, it was renewed for two years by MACRA, but the discussion at the last meeting, there seemed to be an agreement that a future renewal should be longer than two years so that there is time to develop and implement and evaluate some of the other components in the package.

The second decision point that we'll highlight for you today has to do with the maintenance of effort, or the MOE. Under the MOE, just as a reminder, states may not reduce eligibility levels or impose stricter enrollment standards than were in place prior to the ACA. The MOE is in effect through fiscal year 2019, and so our question for you is: Should the MOE continue through then or does the Commission maybe think differently on that?

The last decision point that we'll highlight for you this afternoon relates to the federal matching rate for CHIP. Recall that the ACA increased the CHIP federal matching rate by 23 percentage points from fiscal year 2016 through fiscal year 2019. So the questions for you today are: Should that 23 percentage point bump continue through fiscal year 2019 or beyond? And, two, should the CHIP

enhanced matching rate be changed? For example, prior proposals have suggested a lower matching rate for children with higher incomes at, say, 250 percent of the federal poverty level or 300 percent of the federal poverty level.

So, again, that's CHIP. That's sort of the first component of the package that you have been discussing so far.

I'm going to turn it over to Chris, and he's going to go over the other pieces.

* MR. PETERSON: As Joanne just described, the basic building block for this package is an extension of CHIP. Now I'm going to describe four potential components that could be added on top of an extension of CHIP, and they're all independent of each other. So you could choose to do none or one, two, three, or all four.

The first-order issue for these add-on components is whether to include them at all in your package going forward, and then for any component you might want to include, the second-order issue is to provide as much specificity as possible on the key decision points.

So this one, again, the first bullet says federal CHIP funding is extended for a specified period of time.

For all of these, that is kind of the premise we're building on.

This particular component would build on an extension of CHIP by providing state CHIP programs with a new option, and that would be to purchase an exchange plan for children in CHIP as an alternative to their regular CHIP coverage. This kind of approach can be called premium assistance, although it also involves cost-sharing assistance. And, again, this would be for current CHIP enrollees, so rather than direct CHIP, they would enroll in an exchange plan purchased by CHIP and enhanced by CHIP.

On the decision points, under this approach there are a number of potential decision points. On eligibility, should states be able to expand CHIP eligibility under this option? Currently, states have little flexibility to expand CHIP any farther up the income scale. So, for example, if a state is currently at 250 percent of poverty, should they be able to expand to 300 percent of poverty, 400 percent of poverty? And if so, then what matching rate should apply?

Under current law in CHIP, any new expansion above 300 percent of poverty is not matched at the CHIP

matching rate but at the Medicaid matching rate. Or should eligibility levels just be left alone where they are since it is not a necessary part of this component?

Another decision point is should states have the ability to require enrollment in a CHIP-funded exchange plan rather than direct CHIP? And on affordability, we know that children face a lot more cost sharing in exchange coverage compared to CHIP. So if a state purchases exchange coverage, what are its obligations to make it more affordable? That the national CHIP standard apply of 5 percent of income for premiums and cost sharing? Or does the affordability need to match whatever is done in the state?

Then on benefits, what if the exchange plan doesn't cover pediatric dental, for example? Should the state be required to purchase stand-alone dental coverage, considering that dental coverage is required in CHIP?

And then the last bullet there is the cost-effectiveness test. Should there be a cost-effectiveness test? So under this approach of states purchasing exchange plans for their CHIP-eligible children, would states have to show that their costs by purchasing the exchange plan is

not more than regular CHIP? Or, on the flip side, in order to encourage enrollment in this premium assistance, should there be no cost-effectiveness test? So these are some of the main decision points.

This next little box here, even though it's a few words, is actually pretty complicated: federal exchange subsidies in addition to CHIP subsidies. We want to come away with a clear understanding of what you have in mind, so first some context.

Currently, if children are eligible for CHIP, they are not eligible for exchange subsidies. CHIP trumps exchange subsidies. The question here is: Thinking about children who are enrolled in CHIP, should this policy be changed so that children in CHIP can tap exchange subsidies and then allow CHIP essentially to wrap around that coverage? And if so, that's actually a bigger change than what we've been talking about thus far because up to now we've only been talking about changes to the CHIP statute. But if one were to make this change, then that would require changes to the Affordable Care Act and the Internal Revenue Code, and that could save states money because those funds on exchange subsidies come through the tax code

and not through CHIP.

Then the final point has to do with premium assistance for employer coverage. As we've discussed before and as Joanne will describe in the next session, states have the authority to do premium assistance for employer coverage, but it is often difficult to implement administratively because of various federal requirements. If this new version of premium assistance in CHIP for exchange coverage makes it easier to implement, the question is: Should employer-sponsored insurance also be tied into this? Or, instead, maybe you just want to recommend separately simplifying those other existing authorities for CHIP premium assistance? Or, Option 3, just leave well enough alone. But the next session is going to dig into that bottom box. So that's that component.

Then this one, enhance exchange coverage above CHIP eligibility levels, again, assuming the premise that federal CHIP funding is extended, this component is to enhance exchange coverage for children. So this component is targeted to children who are just above states' CHIP income eligibility levels, that is, to children who are not

eligible for CHIP. So in North Dakota, for example, that's going to be above 175 percent of poverty; different levels in different states.

Again, because this component targets exchange coverage for children and not CHIP coverage, this, too, would require -- this component would require changes to the Affordable Care Act and the Internal Revenue Code.

And so as it says there, for children above current CHIP eligibility levels, enhance exchange coverage to improve coverage, affordability, and adequacy of benefits. And so the decision points basically get at what exactly does that mean. So for eligibility, eligibility for exchange subsidies could be expanded for children. For example, the family glitch could be fixed, so children could be made eligible for exchange subsidies. If family coverage through a parent's job was too expensive under current law, of course, only the self-only premium is taken into account. Or one could go further and bypass the family glitch altogether and match current CHIP rules and say it doesn't matter if children might be eligible for a parent's employer coverage or how much it costs. If they are uninsured, they should be able to obtain the subsidies.

On affordability, then, how much should that coverage cost, including coverage where only the child enrolled in exchange coverage? And should there be a different affordability standard for children compared to adults?

And then with benefits, do benefits for children in exchange coverage need to be enhanced, with dental, for example?

And then, finally, and this is a rather technical issue, but some plans have raised that the way they are required to set premiums across the age groups based on the federal age rating bands, that they are essentially being underpaid for children who enroll. And their argument is that while children are generally less expensive than adults, they aren't that much less. So that might be something to consider if children's exchange coverage is going to be expanded so that more children might be enrolling.

So there's that component, and then I'll hurry through the last two. I think they're more straightforward. This one is to broaden state innovation waivers. This component is to broaden the scope of state

innovation waivers. Under these innovation waivers, Section 1332, currently states only have flexibility around funding generally from exchange coverage and those enrollees. If states want to involve Medicaid and CHIP enrollees, then they have to apply for separate waivers under 1115, and that funding cannot be used across the groups. So the idea with this component, based on comments from the last meeting, would be to take down those walls and allow one waiver to use all of these funding streams and let the states do something comprehensive.

So some decision points. Would all states be able to do this, or would it be limited to just a few? Cost-effectiveness, also known as budget neutrality in this context, would there be a limitation on federal funding based on what the federal government would have spent? And would that be on an aggregate basis or a per capita basis? And, finally, would the children using this money, would that include the funding streams of Medicaid and CHIP and exchange coverage?

So that's that one. And then this final component, in every past CHIP extension a number of other extenders related to children have been included, as you

see here, express lane eligibility, which permits states to rely on findings from certain programs such as SNAP to determine Medicaid or CHIP eligibility. And then there are appropriated amounts for these other grant programs and demonstrations.

And so on the decision points, you see here the amounts, the relatively small dollar amounts, and the question is whether or not to recommend extending these.

So on this last slide, you see the long-term schedule here, but what we want from you today is: First, what components do you want included? And, second, what are your thoughts on the decision points on those components you want to keep? And once those parameters are defined, then we can move forward toward obtaining some cost estimates from the Congressional Budget Office and putting together your package for the fall and winter meetings.

CHAIR ROSENBAUM: Thank you, Chris.

Let me remind everybody just at the outset of this -- and I have identified, like, 14 different issues, which is sort of unwieldy -- that I think we have a crucial decision, which is implied in the title of the memo to us,

but I think we need to be crystal-clear about it, which is, Is the discussion about children's coverage, or is the discussion about CHIP? And some of the questions that the staff have put to us relate to specifically CHIP. How long should CHIP be extended for? How should CHIP funds be available for use to the states?

But then there are questions that go to the broader issue of children's coverage. Should we address the family glitch? Should we make recommended changes in what pediatric coverage means in exchange products? Should we think about recommending a more child-specific approach to how we set the cost of children's coverage through age rating, premium changes?

So we have both kinds of things on the table, and I would actually recommend that we put this huge tranche of decisions into two buckets, one being decisions that really go to how long should CHIP be extended for and what kinds of uses do we want to at least think about recommending, do we want to think about flagging because they may be quite relevant to our recommendations, and then the separate questions on are we making recommendations that go beyond, beyond CHIP, sort of CHIP per se.

So starting with CHIP, I think the threshold question is are we making a recommendation to simply -- not are we making because we're not making recommendations today--are we thinking about an extension beyond simply the two remaining years of the current structure of CHIP? Are we thinking about an extension that essentially gives CHIP a standing that's different from just being a stop-gap financing measure for children? What's our vision of CHIP?

Okay, Kit. Kit is our vision of CHIP.

COMMISSIONER GORTON: Kit is not our vision of CHIP.

So can I ask a framing question? Because I'm not sure how to answer the question. Is the Commission's goal to recommend in the abstract the something-close-to-ideal-future state of children's coverage in the United States over the course of the next 10 years, or -- and I am being deliberately -- I am just trying to strike the opposite ends of a spectrum in which I know we will be in the middle -- or is it the Commission's goal to recommend changes, extension, blah-blah-blah, for CHIP, which have a reasonably high likelihood of being feasible, implementable, and achievable, so that we actually are

recommending something which stands a snowball's chance in hell of getting implemented and actually providing benefit to the children of the country?

So the question -- and I don't think it's a trivial question. I think we really need to say to -- because for me, the answer to every one of these questions starts with, okay, let's look at the range of options, and which of them are nonstarters from the beginning? And let's cross those off. And which of them are slam-dunks and they're easy, and so let's put them in, and let's figure that out?

I'm an operations guy. My job is to build programs and run them. So if what we're looking to do is build a program that we can actually implement, then that's one set of factors. If we're looking to give more -- I don't mean this in a pejorative way, but it's the word that comes to mind -- a more academic treatment of the subject, then that's just a different conversation.

CHAIR ROSENBAUM: Well, I just want to remind people that in our work for Congress a couple of years ago, we took a very, very near-term, very applied, very practical, you know, "Things are in flux. Let's focus on

CHIP," a couple of minor adjustments, couple years of funding, and so we certainly can have another round of very applied, near-term recommendations.

We could also embed those recommendations in a broader set of recommendations that we think Congress ought to have before it when it's making near-term calls. So they're not mutually exclusive, but just for those of you who weren't on the Commission two years ago, we took a very hard-nosed, very short-term approach, and so we have made that choice before.

Alan and then Gustavo, Penny.

COMMISSIONER WEIL: My own framing question, also having not been here the last round, is the level of detail presented here, which makes it possible to score, feels like a mixed blessing, and from where I sit, I'm seeing more negative than positive. And it basically -- in some respects, I think it forces us to take one particular approach, which is "Here is a statute. If we extend it and make these modifications, this is what it will cost," as opposed to "This is where we want to go, and these are some steps in the right direction."

So almost by definition, giving us this list of

choices, which I think is very helpful from a discussion perspective, is also, in some respects, constraining, and so that's my variant on the framing question.

So I am going to just, because I wasn't here -- I mean, here is how I think about where we are, which is we have this phenomenally successful program called CHIP. I mean, we have to start with where we are, which is this program was established to do something, and it did it. And it's doing it, and we don't want to stop doing that until we have something else that's going to be at least as good as that.

But it is sandwiched, and we had a little of this conversation before. It was created in a different environment. We didn't have the ACA. We didn't have exchanges. We didn't have tax credits, and Medicaid has changed in that time. And so now we have this program that is sort of sandwiched in that was designed to fill some holes, and the context around those holes it fills have changed.

So in the long run, if we want to have a program that is as good as what CHIP has done, it probably needs to look different from the program we created when CHIP was

created. So to me, the extent, the time extension is really about giving all of the actors in the system -- the states, the providers, the families -- the time to evolve the system towards something more like what we think makes sense in this environment, but to make sure that we're nudging along that path, so that we don't just stay where we are, but that we're also not pushing change so quickly that we lose what we've done.

Now, talk about an academic, I mean, that's like, you know, but --

CHAIR ROSENBAUM: But you are saying that from your perspective, what you'd like to think about for cost estimation and decision-making purposes is not simply the interim step we took two years ago, but a longer time horizon for our thinking here.

COMMISSIONER WEIL: Well, at least I think embracing a longer time horizon for our vision combined with more precise policy recommendations with cost estimates associated with the next phase of what would get us there seems like the right match.

I don't know what -- I don't know what value a cost estimation for a new vision 10 years from now does,

but I do think giving some kind of an estimate to the cost of a proposal without putting that in the context of why that proposal gets us to where we want to be would be a missed opportunity.

CHAIR ROSENBAUM: I have Gustavo.

COMMISSIONER CRUZ: I mentioned this to Chris before because when I read this last night -- and I read it really thoroughly because I was very interested in this -- I got confused as to exactly what was it that we were doing and some of the specific recommendations here. It gets back to understanding what is it that we do as a Commission and what is it that is our purview.

For example, when there were some decision points related to the benefit standards and the dental coverage, dental coverage is an essential benefit of the exchanges. So it's not that they're not offering dental coverage. It's the way that they are offering because allowing of the stand-alone dental plans.

So if we are going to make recommendations of, for example, all of these changes to actually have a wrap-around medical that includes pediatric dental, we are entering into a field that is not really CHIP or Medicaid.

We are entering into the Affordable Care Act and the implementation of it.

So that's where I was a little bit sort of confused as to what it is we are doing in terms of figuring out the recommendations that we're going to --

CHAIR ROSENBAUM: Well, and I think Alan answered -- Kit's beginning and Alan's addition, it seems to me that, again, unlike what we did two years ago where it really was an interim recommendation meant to deal with a very specific issue, that here there are near-term aspects to our decision, but that by virtue even of the example you just gave, you are sort of illustrating Alan's point that given how much the context has changed, you necessarily have to think about children's coverage as opposed to just CHIP specifically.

Penny and then Sharon, Peter.

COMMISSIONER THOMPSON: So I agree with all that has been said, and I am happy to build on that commentary with this thought, which is I think in the last conversation, we talked about -- I think, Alan, you've made this point -- about the success of CHIP. Let's not sort of become enticed by the possibility of things that could

improve on it without some actual demonstration and proof that that has occurred, and so I like the idea of talking about this as stabilizing CHIP, allowing the evolution and experimentation that will produce actual information that will determine what we have that we want to potentially institutionalize nationally.

And I just want to talk about, like, what that timeline looks like because I think that goes back to this issue of how long are we suggesting that we extend CHIP to. This is not a small matter that we are talking about taking on. If you think about it as sort of establishing a statutory framework, allowing the feds some time to think about how they are going to administer that, giving states time to plan and engage stakeholders, encouraging maybe a couple of different approaches that states are going to be trying, allowing them to actually try it, including maybe some states not trying it, evaluating the results, determining what you think that means for a new legislative proposal at the national level. It's hard for me to see how all of that happens in something less than six or seven or eight years.

And so I just want to put that out there as a

potential way to think about if that's -- if we're talking about a journey and allowing room for the journey and allowing states to be participatory in that journey and wanting to actually collect and use data before something that gets imposed on the nation as the framework for children's coverage, I think that's the kind of timeline that we're talking about.

CHAIR ROSENBAUM: Knowing how much the staff wants us to make some decisions to help guide them, it sounds like -- and stop me if I'm wrong, but it sounds like we're not doing a repeat of what we did the last time, which was a very short, very tight time frame. We see that CHIP embodies much about pediatric coverage for itself and for the broader lessons we will learn from it, so we are asking, I think, if I am reading the group right -- we are leaning toward asking staff to explore a long time frame for CHIP, a 10-year window for CHIP.

I probably would have upped my number by at least two, but I think Penny's way of explaining the time frame is a good one.

Chuck.

COMMISSIONER MILLIGAN: Well, I'll wait on

commenting on that. Maybe other people are --

CHAIR ROSENBAUM: Yeah. Sharon, Peter, then Chuck.

COMMISSIONER CARTE: I am in full agreement with what was just said, and I appreciate Kit saying at the outset that he wasn't sure how to answer because if we're commenting or recommending just about CHIP as opposed to children's coverage, I just once again need to say that for myself that CHIP has become so much about children's coverage that we would not want to go backwards in any respect.

But as far as the question about time span, one item that I'd like to mention is that -- because both Medicaid and CHIP officials have been very concerned with it, if it were to be a short time span, but even with a longer one, that consideration be built into that time span for the time that it takes state programs to do a phase-out, and that that be a discrete part of that.

And then another thing I wanted to ask Sara is how much -- well, if we're talking about that long, long time span, it may not be as problematic, but I was struggling with how much to ask staff to do on some of the

decision points, like, for example, employer coverage, things like that, where there's already so many structural barriers. Even though that could be totally viable under one set of circumstances, I don't see asking them to go there right now. So how do we look at prioritizing what decision points to work on?

And I think I had one other question, but I think I've forgotten it. Okay, I'll stop there.

CHAIR ROSENBAUM: I think once we get beyond this threshold question, then the question becomes what uses do we want CHIP funds to be put toward, and that goes to Sharon's point of which things seem to be sort of consistent with where the world is evolving to and which things may be nice but less of a priority.

Peter.

COMMISSIONER SZILAGYI: Yeah. Thank you. I think Alan elucidated what I was going to say beautifully and much better than I was able to say it.

I do think I agree that there is a tremendous amount of evidence about the benefit of this very low-cost program for a very large number of children, and my biggest worry about what we had been discussing in terms of the

exchange is that we would do harm. And to do harm in a program that has done a lot of good just doesn't seem right, where there actually is evidence, and there's so little evidence in much of other child health care.

So to me, the threshold -- I mean, it took 10 years to figure out that CHIP worked, and so to me, a 10-year -- in the current context, in a current different environment, I would think that a 10-year window would make more sense.

There's one area, though, that I think CHIP maybe hasn't done as well as it could, and that is -- and I continue to be concerned. There's so much evidence now that kids between 200 and 300 percent of the poverty level are kind of are just about as much at risk as what we used to think of kids before between 100 and 200 percent of the poverty level. Their health outcomes as children is low. Their health outcomes as adults is low, and I continue to be very disturbed by -- on the one hand, I am true believer in state innovations and giving power and flexibility at more local levels because that's where ingenuity really happens. On the other hand, why if you're a child in one state and if you're at 250 percent of the poverty level,

you may not have access to CHIP when it's been demonstrated in another state to be very effective? And that continues to bother me.

And to me, the decision is a little bit different for children than it is for adults, and I don't know whether this is a justice issue or it's an evidence issue because we have more evidence for children, but it is a major issue in my mind.

COMMISSIONER MILLIGAN: So I think I want to address my comments from a different direction, and I think, Sara, to your framing, I think I don't agree with some of the time horizon and conversations about this.

To me, what I think about in terms of -- starting with the end in mind, to me the end in mind is do no harm version. Peter, it's kids' coverage more than CHIP as a program. And so to me, starting with the end in mind, the affordability piece, the dental piece, the family glitch piece, those need to be fixed.

When I start with the end in mind, I think for me, just for me, it means taking into consideration the new factors that Alan mentioned, the Affordable Care Act exchanges, APTCs, all that stuff. So what I think of as do

no harm for the children is: How do we get to a place where exchange coverage is adequate and affordable? And what is the time horizon to make a transition? And so I think in terms of, Chris and Joanne, your questions, it's scoring things like the family glitch, scoring things like dental coverage, scoring things like the cost sharing in CHIP being more favorable. And the reason I -- and what's the time horizon to get there with a responsible transition and for CHIP itself to sunset at some point?

I guess the way -- and one of the reasons that -- sorry, two quick final comments. The first is I think of a ten-year time horizon as very long. I mean, the Affordable Care Act was passed on March 23, 2010, and the exchanges went live January 1, 2014, so less than four years. A ton of work Penny and others were involved in, but I think that a ten-year time horizon is a very long time.

But my last comment -- and I want to conclude with picking up on something Peter said -- I just continue to be troubled with the state variability around CHIP, and your luck as a child totally depends on which state you live in and what poverty level that CHIP program reaches at what ages. And I think the Affordable Care Act and other

intervening factors need to be addressed in terms of just equity nationally about the exchange and coverage and subsidies. And I do continue to be troubled by the notion that kind of rolling this down the road as is -- I mean, nobody's quite saying that -- continues to bias those -- is biased against those children who are unlucky enough to be in the wrong state, quote-unquote.

CHAIR ROSENBAUM: Well, you get to -- again, going back to where we started the discussion -- this crucial tension between if our focus is really on children and children's coverage, that we can have a robust set of CHIP recommendations both how long, what it can do, all those things, what additional state options do we want to create, but that by itself may not be where we want to stop as a Commission for the very point you raise, which is we are very concerned if one of our guiding principles in all of this is equity for children, that we are -- we acknowledge all the good CHIP has done, but we realize that CHIP by itself cannot produce equity, not unless we fundamentally change the structure of CHIP. And we could decide that CHIP should become a program with many more minimum performance requirements or, as Alan suggested, we

can recognize the fact that CHIP is now juxtaposed against a nationally uniform program. And so what we want to do is couple a series of CHIP recommendations and some flexibility in CHIP with an additional set of recommendations designed to deal with the limits of CHIP, basically, by looking to the other source of coverage for children, and not try and push it all into CHIP but make it a better companion.

COMMISSIONER DOUGLAS: I'll be short. Just on this time horizon question, I agree with Penny, it's, you know, somewhere in the six to ten, and I think part of deciding where that is we need to do -- once we get through all these questions -- more of just an analytical of how long each of these major steps take in terms of, you know, from the federal to the state policymaking to the operation to how long we think it needs to be in place before we evaluate to really give Congress a clear sense of why we're saying that number of years, because right now ten seems really long, too long, but maybe it's -- I mean, depending on how long these chunks are, that will help us define it.

CHAIR ROSENBAUM: Well, I think, again, in addition to understanding -- it sounds like we want a time

horizon that's more than just a two-year interim fix. We want a longer time period, but we're also, it sounds to me, leaning in a direction of not piling on to CHIP everything that might be needed to fix children's coverage, at least publicly -- let's put aside, you know, directly publicly subsidized children's coverage, meaning the exchange subsidy system as well, that we are also sort of sensing the value potentially of leaving CHIP as fundamentally what it is, which is a highly flexible program that states can use in different ways, subject to certain requirements, but that the flip side of that is that, therefore, in many states CHIP will not go as far as it needs to go.

And so, again, we are saying some period of time for CHIP, some set of recommendations for CHIP, and we need to come back to what those would be, and then a companion set of recommendations that would speak to the nationally uniform program we now have running alongside CHIP which picks up where CHIP leaves off. And that, of course, is a permanent authority. That does not have a sunset period, which is another interesting twist on the whole thing. And the question is: If you have one part of children's coverage, publicly financed children's coverage, being now

a permanent authority on the landscape, which could change, obviously -- Congress could change the law -- do we leave this interim piece still subject to time limits? And there you get to Chuck's point about ultimately seeing CHIP still as transitional into something else.

EXECUTIVE DIRECTOR SCHWARTZ: I just want to ask a clarifying question for staff. I get the issue around thinking about -- for some of these longer-term horizon things, to be thinking about the implementation steps and who needs to do what is part of the time horizon. But what I'm a little confused about is the notion about waiting for evaluation results to do that, because that makes total sense to me in sort of what I would call the blue sky piece of this, the innovation waivers that Alan kind of put on the table last time, versus other kinds of changes that you might want to make in the exchange. What are we -- what would you be suggesting that we should be evaluating to get the results from before we could make a decision about that?

COMMISSIONER WEIL: I'm not quite going to answer that, but I am trying to bridge the gap between the ten and two years, because I find myself, like Chuck, getting

nervous about ten -- I mean, I think there's a difference between structural changes that probably should be made in -- forgive the vagueness -- relatively short order to harmonize CHIP with the environment it now finds itself in, which should not wait for ten years, and the potential for more dramatic shifts that require experimentation and evaluation. I wish I could quickly think of an obvious candidate for Category 1 and Category 2, which is, I think, in some sense what you're asking. That would take a little bit more time. But I do think we are in some respects talking about two different things, sort of programmatic changes that don't -- that can't happen tomorrow, but don't need this long lead time, and real, you know, fundamental shifts that do require that.

COMMISSIONER DOUGLAS: Well, let me -- even if we do -- permitting optional CHIP-financed exchange subsidies, that's going to take time, right? I mean, that's going to take at least a couple years for states to even implement given the timeline for -- and then you evaluate for three years or whatever, so then you're talking six, seven years down before you really know --

CHAIR ROSENBAUM: Well, but there are states

today, for example -- putting CHIP aside, there are states today that supplement the exchange subsidies. They buy up the value more for people. So I think -- I just don't want us to overstate how much, you know, new trail we're cutting here versus letting states draw from the existing examples of where an analogous thing is happening and just say it's okay to use your federal CHIP financing this way.

So there may be shifts that really do require a delivery or an enrollment innovation or, you know, a financing innovation. And there are some which I think are a little bit simpler, where we're saying given where the world has moved, it makes sense to allow a state to use federal CHIP financing in a certain way. I think we're still sort of stuck on -- not stuck, but we still are struggling, I would say, with Chuck's question of whether CHIP continues for some period of time as an intermediate step to a more unified system of publicly financed coverage for children who don't qualify for Medicaid or whether CHIP has enough integrity -- I mean that in just a structural sense -- as a program to want to keep something -- a brand called CHIP and building out children's coverage principles from CHIP.

COMMISSIONER CARTE: One point that Chris brought up that speaks to that issue, the integrity of CHIP as a program, and that was the role of enhanced match currently for CHIP. Just having been at meetings with other CHIP and Medicaid officials, I would say that more states, you know, find themselves in a precarious budgetary position where it would be very difficult to maintain that without that enhanced match, and that we could see states starting to make these decisions almost by default so that you'd see even greater variability; whereas, right now we have over 20 states that, you know, have 95 percent or higher coverage of their child population under some source. So, again, that's another thing that also speaks to the time horizon question.

CHAIR ROSENBAUM: Do we want to ask staff to come back with, for example, a sense of what a five- to seven-year horizon or a four- to six-year horizon would be like at the current enhanced federal matching rate with certain enhancements in states' flexible use of CHIP funding? In other words, I'm trying to get us back to the questions that Chris and Joanne have posed, realizing that we're struggling here, the framing, but we've -- it feels like we

know at this point enough about these tensions we're trying to balance off in the framing, to begin to give staff some feel for what we'd like them to come back with.

For example, we could say that we have enough sense that CHIP should continue as a thing to let it continue as a program of its own, not for just the two years of funding but for longer than that, because there are a number of issues that CHIP is still dealing with and it takes a long time to put change into place. And we have enough of a feel to know that there are a couple of uses of CHIP funds we'd like you to contemplate at this point in the specifications you begin to work up for us. Or are we, you know, so uncertain about CHIP that we can't give the staff any guidance?

MR. PETERSON: I think I can help with that, but I think I need to give a little context first, and I think it bridges what Kit and Alan kind of started off with, so let me try with a bit of a framing discussion in terms of -- it seems like the base, we're all on the same page, is an extension of CHIP, and that addresses the short-term issue. Now you're addressing what's the vision, and I think the Commission has expressed that vision. It's a question of

how do we get to that place and what is that place. And I think the components that we have come up with were not to say we know what that place is right now and where it should be. Those components are saying we don't know necessarily what they are, but we're going to give options. And are they options of -- the first one is kind of the premium assistance thing, keep it within CHIP, give you more flexibility on that front, or do we start doing things in exchange coverage now for kids -- which is a different question -- or do we do this broader innovation waiver and let a broader kind of experimentation go on?

CHAIR ROSENBAUM: Or do we do something simultaneously [off microphone].

MR. PETERSON: Yes. Now, do you want me to talk a little bit about the CBO things of what we think we know at this point? So first let's talk about an extension of CHIP and forget the other pieces.

We know that the two-year extension of MACRA, CBO estimated that that would cost $5.6 billion. Now, granted, CHIP costs on an annual basis about, you know, 10 to 13, if I'm remembering off the top of my head, somewhere in that ballpark. So it's a lot less when you're talking about how

CBO does its estimates, and we can talk about why that's what it is. But $5.6 billion is what they estimated the CHIP extension costs in MACRA. That was assuming the 23 percentage point increase goes into effect.

Before that, the Commission had requested cost estimates from CBO, and one of the permutations that they gave us also was what if that 23-point bump were not included, and their estimate then was that an extension of CHIP would actually save up to $5 billion.

So I think the question you'll have to think about is: Is it okay to do away with that 23 percentage point bump? And does that matter in terms of paying for a longer extension? I think those other components, the second one on premium assistance, it depends on its design, but if it is literally just giving a state opinion, an additional state option for kids who are already eligible for CHIP, then that could be a fairly low cost.

The next piece is if you go into exchange coverage and you make more kids eligible and you give them more stuff, then that could be very expensive, depending on how many more kids and what you give them.

And to your point about when the CHIP money runs

out is if you extend CHIP for five years but this change in exchange coverage is in perpetuity, then once the CHIP money ends and all these kids go to exchange coverage, then that costs even more money, that particular thing.

And then the final one is on the innovation waivers. You could design that to say it has to be budget neutral and the cost is negligible. But that's just an overview of kind of how much these things might cost and some considerations.

COMMISSIONER COHEN: And is CHIP in the CBO baseline in perpetuity more or less at this point?

MR. PETERSON: They are required to assume that the CHIP program continues at $5.7 billion a year. So it is not fully funded. It's partially funded. It's a weird budget rule, and we can talk about that. But that's what the status is.

COMMISSIONER COHEN: All right. So moving -- that was helpful and grounding. Thank you. But sort of moving back, I think, to this question about sort of how does the Commission address a long-term vision, a short-term need for a real concrete recommendation, because Congress is going to have to do something, and we feel like

we want to say something about that. And I do want to, first of all, separate out two issues.

There's an issue of implementation time -- right? -- which is always longer than you want it to be but is variable and people have done things very quickly and not as well as they have wanted to, and they've done things slowly and not as well as they wanted to. But implementation time is not the issue that we're talking about here. Right?

I think what we're really talking about here is that we have gotten to a point as a group -- I'm just throwing this out there, and I'm not saying that we are at sort of perfect agreement, but we have a direction and a vision that I think we have talked about enough that there's some real comfort with it, and it sort of goes to changing CHIP program's structure in the ways that Alan talked about to sort of be more aligned with the coverage that we have. But I think what we're also saying is that we are not really ready to birth a fully fleshed out proposal for legislation in the next few months that addresses all the sort of details necessary for a really good score -- I don't mean a “good” score, but a score that

meaningfully reflects the policies of that long-term vision. And, I mean, you can sort of address the problem in a couple of ways, but one of them, I think -- and it's all been alluded to. I'm sort of only summing up -- you know, are there modular sort of like policy steps that we can take where our first step -- because Congress has to act and, therefore, we really need to act -- is to say right now, you know, if we were Members of Congress, what we would do or want to do is, you know, an extension of CHIP that does not put the program's, you know, mid-term future in doubt repeatedly over the next few years, and that, furthermore, takes some key steps in the direction of implementing -- and I don't mean -- sorry, not implementing, but sort of advancing sort of a legislative vision, but we are not quite ready to do the full monty of really designing it for the sort of ultimate goal that we have.

So I would just propose as a set of steps that we might want to sort of do a shorter-term recommendation and set out the vision that --

CHAIR ROSENBAUM: But are you suggesting, then, that we are not ready to make any very specific

recommendations on the pediatric coverage side of things, not on the CHIP side of things, but on the pediatric coverage, the bigger picture side of things, such as the family glitch, such as --

COMMISSIONER COHEN: No, I think that very well could be --

CHAIR ROSENBAUM: Those are very specific. Okay.

COMMISSIONER COHEN: -- one of our concrete step-wise steps.

CHAIR ROSENBAUM: Okay.

COMMISSIONER COHEN: And I just want to mention one other thing, which is a little bit off of that particular topic of addressing this issue of sort of both timeline and readiness and potential building blocks of policy recommendations.

I do think that we -- we've talked about this in some context, but I just feel like I always need to come back to it. There is no program that is really designed to sort of be the governmental, both expert and sort of accountable entity for the health of children, right? We have the agencies that have different capacities. They don't all have them for people with mental health, sort of

mental health and other areas. Medicare really addresses a very distinct population, several distinct populations, et cetera.

I do think that one opportunity here is to just think structurally a little bit about creating sort of a locus, a focus on children's coverage. Again, not CHIP, which has kind of been like a proxy for it because it is the only pure program that focuses on children's coverage. It just happens to be a very, very small number of children, but I would like to put sort of an element of that structural piece into a proposal that we would think about, whether it's at the vision point or the policy recommendation, and it's not about creating a new bureaucracy necessarily or something like that, but I think sort of creating a notion that we are thinking about a sort of children's coverage endeavor using CHIP dollars as a tool, but to sort of thing a little bit bigger and think about how we can make structural a place at the federal government level to think about children's coverage more generally. I think that's a piece that we talked about, and I'd like to have it sort of included more explicitly in some of our going-forward pieces, if others agree.

CHAIR ROSENBAUM: Okay. Well, I am mindful of time here, and I have Chuck, Marsha, Alan, Penny, and Sharon.

And here is what I would suggest, that we get through the next round of questions. Very quickly, Joanne, if you could move us through just very quickly the premium assistance question because it does feed into this, and so that we can come back and let things sort of filter through a little bit, so that staff end up with some direction.

So why don't we go through the questions remaining, then the quick presentation, and then back to discussion.

So, Chuck.

COMMISSIONER MILLIGAN: I'll be brief, I hope.

I think there is one fundamental area where I may not be in agreement with what the consensus is that I am hearing. Imagine one scenario where, nationally, you could have a CHIP-like coverage, family glitch panel, all of that, and cover every kid in the exchange with wraparound financing up to 185 percent of poverty -- I'm making that number up -- that's equivalent cost to taking the existing CHIP program with the 23 percent and extending it.

185 percent of poverty nationally might have redistributive consequences across states versus the model of CHIP, which is every state has their allocation, and they can then do with how much we want to buy up the actuarial value, how much we want to do employer premium assistance. And what I'm hearing from the Commissioners is more of the state allocation trending forward and then figuring out how to maybe innovate with the state exchange and state model versus what I think of as more of a children's coverage strategy, which is more of a national base.

And so I guess what I want to say is maybe from a CBO perspective, taking the existing CHIP program with the 23 percent bump over a 6-year time horizon, whatever, how much could that equivalent -- thinking of CHIP as funding, not as a program, thinking of it as a financing amount, not as a program, how much could that buy up, wrap-around, cost-sharing reductions and benefits? What percent of poverty does that get us to nationally?

What I was hearing was continuing almost a state-specific allocation model, which I think doesn't reflect the ACA as a national exchange subsidy model. And by the

way, when we get to DSH down the road over the years, this is to me a version of it. Is it a state allocation, or should it be redistributive across states?

But I'll stop there.

CHAIR ROSENBAUM: Marsha and then Toby.

VICE CHAIR GOLD: Yeah. I think only probably about four of the Commissioners were on -- not including me, were on the Commission when the two-year extension was taken up, so sort of understanding some of that history is important.

I guess listening to it for the two years I have been on the Commission and trying to make sense of all the policies, it seems like the one really solid point of consensus, I think, has been that the gain in children's coverage shouldn't be hurt, that we have really made progress with children's coverage, and it would be bad to do that.

Now, the ACA assumes that you could maintain that, I think. If I look it over, in four years, it would phase out, and you could have it in. I think the good work staff have done have pointed out some real shortfalls, given the ACA benefit package and the way things are

structured now with how children's coverage would be affected if one just folded that in, and so a two-year extension sort of puts you back where they were. And we're not really further along in dealing with some of the limitations. So it seems to me that somewhere longer than two years is important from that perspective.

On the other hand, I personally don't know that on that, I'm in favor of just maintaining a program because it's a program as opposed to the coverage issue, and so I think part of the issue is you've also shown with the work you've done that it would be really expensive to fix ACA for children's coverage overall.

What I hear people sort of struggling with is how do you trade off making the feasibility of a more fundamental change versus fixing CHIP, so at least this children's coverage doesn't get any worse. And I'm not sure how you do that.

I do think leaving states with just two years, it just leaves them hanging some more. I've been convinced enough listening to people that it makes no sense from a policy perspective when you have legislators on the line to be doing things in two-year increments, so you need more

time, whichever you go, but there is this issue of how to do it. And some of that, Congress could go one way or another. It depends how much money they're willing to spend on it to achieve the same goal.

CHAIR ROSENBAUM: Toby.

COMMISSIONER DOUGLAS: So I guess I am a little struggling on some of the conversation because I don't disagree with what -- Chuck, what you're saying, but I thought we kind of went through our structure in the previous meetings of really trying to build off of state flexibility. When we talk about creating more of a standardized income level or looking at that, it almost feels like we then need to go back to kind of setting our policy goals before we even start fleshing out some of these proposals. Am I the only one who's seeing that?

CHAIR ROSENBAUM: Well, I think --

COMMISSIONER DOUGLAS: Because I have a feeling like we are revisiting some of it, which is not -- I don't want to -- if that's where we need to go, I don't want to -- but I'm feeling a tension here.

COMMISSIONER MILLIGAN: So I guess I mainly want to just call the issue out. I did, at the last meeting,

talk about as a principal equity, and I did articulate that meant national equity. So it wasn't -- this comment I just made wasn't the first time I made it.

COMMISSIONER DOUGLAS: I don't mean to say that I don't want to hear -- I just was questioning even getting down to some of these levels. Maybe we need to stop in deciding in some of our policy goals.

CHAIR ROSENBAUM: Yeah. I mean, I do think there is this tension in the room, and there's been the tension for a while. And part of the tension is the result of the fact that the national equity system we have isn't adequate for children. It isn't adequate in terms of the affordability. It's inadequate in terms of the scope of the benefits.

And I should note -- and this is a discussion I was having with Andy before -- that there's something else that we should be aware of, which is that in articulating implementation standards for exchange coverage and specifically essential health benefits, which of course guide the exchange coverage standards, the administration has been quite clear that it considers more generous treatment of pediatric coverage, either in terms of cost

sharing or in terms of scope of benefits as discrimination based on age, which I have to tell you since it has first surfaced -- it is in the notice of benefit and payment parameters; it is in examples given in the preamble to the rule -- had totally flummoxed me because, in fact, pediatrics is a benefic class within the structure, which means within a national structure, we should be able to have a nationally uniform subsidy standard, affordability standard, and nationally uniform benefits efficiency standard, all the things that Chuck was talking about, with then CHIP allotments being used for states to enhance pediatric delivery, pediatric quality, all of the tremendously difficult things about getting appropriate services to children that you want to arm states with the money to do enhancements for.

But we are suffering with two realities today. One is that the Affordable Care Act does not create a very strong national standard, that efforts to improve that standard for children have been turned back as discrimination, and several legal theories have been put forward about how to make improvements. And they have essentially been discounted as discriminatory, and so that

then turns us back to CHIP and this feeling that, you know, do you want to take a tool out of the tool box that is allowing some states to forge ahead outside of the EHB super structure.

So, I mean, this is the dilemma, and what we're doing here today is playing out this dilemma. The reality is we have to somehow accommodate the need for state innovation and flexibility, precisely because the national standard is weak, and the question is what do we do about that.

So let me go to Alan, Penny, Sharon, Peter, and Kit.

COMMISSIONER WEIL: Okay. I've spent enough of my career as a staffer that I can only imagine how confused you all are, so I am going to try to do something constructive for a change.

What I am experiencing as a relatively new Commissioner is that you all presented us and we agreed on criteria, and now you came to us with design options. And we said we don't want to answer your question.

CHAIR ROSENBAUM: Right, exactly.

COMMISSIONER WEIL: So what I'm trying to think

of is why the mismatch, and part of it is that we, I think, collectively are feeling -- even though I wasn't part of the last one, we're feeling we're in a different place than last time, and we don't want to just jump to design issues. We want to go through another step. So what I want to try to do is say what I think I'm hearing the step is, which is that there needs to be more attention to the vision to which the criteria will apply before we can give you anything helpful with respect to design options.

So we're trying to figure out how does CHIP relate to employer coverage, how does it relate Medicaid, how does it relate to exchange coverage, how does it relate to cross-state equity. Those issues have to give some texture to the vision that then lets us start talking about design options, so I think that's sort of the step that we're hungry for to make it possible to give you more guidance. And I also think the whole timing issue, there is this difference between things that we kind of have a clear vision, and so we just need to go do them, and where the vision is not clear, so we need to learn more and have experimentation but flexibility to try to figure out how to get there.

So maybe that's still too abstract, but I'm hearing -- and feeling myself -- that in order to do what you asked us to do today, we've got to stop and ask what are we trying to accomplish, and then I think it will be a lot easier to answer the question: So is this a box we want to check, or is this a box we don't want to check?

CHAIR ROSENBAUM: Penny.

COMMISSIONER THOMPSON: I'm trying to think if Alan's comment makes me reconsider mine.

But I wanted to build on, Toby, what you had to say, because what I was also trying to do was keep consistent with our earlier conversation about keeping states in the game, that a big part of what has made CHIP successful has been states being excited and enthusiastic about embracing CHIP, and that we could conceive of ways in which states might be able to think about structuring their programs.

This doesn't address, Chuck, your equity issue, but that states would have some options to think about restructuring their markets and programs in ways that could tell us a lot about what really works and what doesn't work.

I was struck by some of the public comments that we got in our last meeting about maybe we're over-valuing, for example, putting everybody in the same family coverage. Maybe that really doesn't matter so much to people, and maybe we're underestimating implementation challenges. And I know we'll hear about premium assistance, but premium assistance ain't no easy thing.

It may be that we could conceive of a variety of ways in which that concept can be much more easily administered with much greater effect, but that will probably take some actual practical application and experimentation to really understand what really works and what doesn't work.

So just this -- back to like the time frame, what my thought was just about these six years, seven, it was really about the idea that there would be states involved in doing different things, and that in order to accommodate any kind of that experimentation, there's a certain amount of minimum authority that has to operate underneath of that where they're sure about their ability to continue and invest in those different kinds of designs and implementation and for us to capture and analyze what has

really happened in order to inform any national policy.

CHAIR ROSENBAUM: And it's precisely because the national backdrop now, which is essentially the system that makes CHIP obsolete, is not up to the task, and so we continue to need this overlay and what ought to be the parameters of this overlay during some period of time. What do we need to do?

And let's be frank. We're laboring in a situation where we don't know that the national overlay, as we understand it today, is going to be the national overlay two years from now. So I think that has to be a reality that is informing the duration of CHIP extension and the uses that we allow states to put CHIP to and whether we in fact strengthen CHIP in certain ways from a national perspective, precisely because we don't know what's coming.

Sharon, Peter, and Stacey.

COMMISSIONER CARTE: Those points that Chris bulleted that were so helpful in grounding, I was wondering if it would be possible -- because they do relate to the CBO scoring and the relative amount that it costs, would it be possible for you to bullet those out for us in writing, maybe put them on a slide?

CHAIR ROSENBAUM: What you told us before, yeah.

COMMISSIONER CARTE: Because they're more concrete to the CHIP issue.

CHAIR ROSENBAUM: Good. Great.

Peter.

COMMISSIONER SZILAGYI: I think we are all struggling with balancing many of the same sort of principles, and for me internally, part of it is this issue of state flexibility and what we've learned and the equity issue. To me, equity is most important for the most vulnerable, and I'm also trying to balance that with what little I know or what I do know about children's health and who is vulnerable. And I actually don't think the cut point is 185 percent of poverty level. I think the evidence is much more, that it's between 2- and 300, and maybe it's 250 percent of the poverty level. So I almost wonder about a scoring, if we take Chuck's example but go up to 250 percent, what is the cost. What would the cost be? Bring all states up to 250.

To me, the state flexibility is most valuable for the higher -- I don't even want to say higher income because we're not talking about high income. We're talking

about still very low income, but higher than the 250 percent of the poverty level. So I'm trying to balance equity for the most vulnerable, which used to be maybe 100 percent of the poverty level -- and now it really is more like 250 -- and the state flexibility in what we can learn. I could certainly live with the six to seven or eight years. It clearly has to be much more than two.

CHAIR ROSENBAUM: Kit.

COMMISSIONER GORTON: Okay. So building on -- I should have written down who said what, but building on previous comments -- I think it was you, Sara -- about the idea that the ACA would somehow create this national overlay, would create a successor program to CHIP, which would make it possible for CHIP to go away, that was the working assumption. What we're now saying is CHIP can't go away because the ACA, as currently structured, is inadequate to support it, so CHIP has to continue.

And I think we've actually laid out in a fair amount of detail with a fair amount of work that staff has already done what the gaps are and what it takes to close those gaps. So it seems to me that we have at least the bones of a straw model that says what we're looking for is

a transition to the successor for CHIP, viewing CHIP as a funding stream, and that it needs to continue its current form until we close the following enumerated set of gaps, which I think are all here.

And so I guess my one suggestion is I actually think that we could ask the staff to lay out that straw model, and with that straw model in front of us, we could answer some of these other questions in a fairly straightforward manner. If that's the transition we're talking about, then I think, Penny -- I would agree with Penny. We're talking about six to eight years.

I think we know what the numbers look like. I guess acknowledging and wanting to be respectful of Chuck’s and others’ passion about health equity, the national overlay is weak because we don't have a national consensus about health equity.

And going back to my initial framing question, if we really want to accomplish something that actually could be made real, then I don't happen to think we can address that question in the course of the next two years of the legislative calendar because there is not a national consensus. In fact, you have states who have said "hell,

no" and have turned their backs on billions of dollars of federal funding because they don't like the federal funding because they don't like the federal strings that come with them. And we may not agree with that, but I think we at least have to be respectful of the electorates in those states' rights to make that decision in our current constitutional framework.

And so I don't think the current challenge we have -- my view; you may disagree -- is in fact a viable vehicle to address health equity issues. So I would suggest the reason CHIP has been successful -- we've said this in this room multiple times -- is because we let states have a lot of flexibility and do what made sense to them in their context.

And so I would suggest that against the backdrop of the "do no harm" kind of piece, that that's a policy piece, right, where CHIP was successful because we let the states exercise thought leadership and express their context in their own way. I don't think we should take that off the table because I think it adds enormous risk, execution risk to this.

So what I would suggest is that we take health

equity off the table for this particular exercise, that we ask staff, based on what we've talked about here, to lay out a straw model, and I don't think we need to wait until the next meeting to sort of say, "Okay. This is what it looks like." If that's the path, then we're talking about six to eight years. We're talking about these five major program revisions. We can score those things. We know what populations that will bring in, and then that gets us to a place where CBO can do its work, and then we can have some of these higher-level philosophical arguments, which I think would fall under Alan's proposed innovation waivers. These are things that we're going to have to do experiments, and the states are the laboratories for these experiments, so we ought to think about that.

CHAIR ROSENBAUM: Yes. And just to remind everybody, what we did in the last report on CHIP was we had a list of things that were needed to be able to let CHIP go, and we decided that it was reasonable to fund CHIP for a couple of years because it was reasonable to expect that these things could be done. These are just high-level policy questions, not the implementation issues, but high-level policy changes having to do with national health

equity.

Needless to say, those things have not happened, and it may well be that we will decide to be consistent with our last message, except this time recognizing that with the change in administrations and with the longer period of time needed to sort of figure out the backdrop we're working against, that we are recommending a longer time horizon put against a national equity background, so not letting national health equity go, but noting that one program is a state program and one program is a federal program, although I do think that Peter makes an interesting suggestion, which is within the state program, we could ask staff to look at certain minimum standards that aren't there today, like bringing everybody, every state up to 250 percent of poverty, which may have some interesting effects in terms of federal outlays for premium subsidies.

But I don't think it's quite as black/white as it might seem, but it is sounding as though where we're going is very much like where we went two years ago, which is a continuation of a program to deal with the fact that the underlying national structure is simply not ready for prime

time where children are concerned, nor does there seem to be an inclination at this point to allow the states to make the kinds of adjustments within the regulated insurance market to give a higher benefit to children because that would be considered age discrimination. And that leaves us in a position of continuing this stream of funding, subject to maybe some stronger recommendations about what the stream should look like. And then the question becomes how long do we do that for.

If you look back at our -- what would it be? 2015 report? I've lost track of the year -- 2014 report and you tick off the national reforms that we said were needed to make the marketplace work, we're all saying the same thing today, and we're now coming into an era of tremendously consequential decisions that will be made.

So, Stacey, I know you had a comment.

COMMISSIONER LAMPKIN: Just trying to tie some of the pieces of this together, does the permit optional CHIP-financed exchange subsidies, doesn't that essentially serve as a demonstration for the states that choose to go down that path and allow them to test the supplemental -- the parameters under which they would supplement, and then the

six- to eight-year time period, that's what the evaluation is. What are the permanent changes that are --

COMMISSIONER THOMPSON: In addition to the state innovation waivers, which I think are also in that bucket of things states could be trying that could lead to recommendations for national policy.

COMMISSIONER LAMPKIN: So it feels like we have the skeleton of a straw man here, that it's just a matter of we need to flesh it out by making some of these decisions that staff has asked for.

CHAIR ROSENBAUM: It sounds to me like the things we're asking for are can we peg a five-year horizon sort of a midpoint between two and ten as a starting point for us? I mean, it really doesn't matter to me. The point is we're sending a message that's longer than two. Okay? And another is that we're interested in knowing what the effects would be if we set a minimum standard of 250 percent of poverty. And you could give us gradients, 200 percent, 250 percent, for state performance, what it would cost to get all states up to that level of children. I can tell you the children of Virginia where I live would thank us. We are a state that is considerably below that level.

And what it would be to give states the flexibility to supplement exchange subsidies to bring the actuarial value of -- if they want to buy an exchange plan, two things: one is to be able to enrich the product, to set aside this concept that it's age discrimination, so to be able to do a richer benefit package as a matter of state insurance regulation; and, two, to bring the actuarial value up to, say, 90 percent -- anywhere from 90 to 95 percent, which is about where we are with CHIP, so to broaden states' buying power, okay?

And then the question, which we never got to is, is whether an additional form of flexibility ought to be to allow states to use their CHIP buying power more effectively around employer premium assistance. Do you want to -- we are into break time, but can you take like a minute and just explain briefly what the premium assistance issue is.

MS. JEE: Sure. No problem.

CHAIR ROSENBAUM: So the people can decide if we want it on our shopping list.

PREMIUM ASSISTANCE FOR PURCHASE OF EMPLOYER COVERAGE UNDER CHIP

* MS. JEE: Okay. I will bottom-line it.

So states, in fact, do have authorities to operate premium assistance programs on employer-sponsored coverage. There are some rules around that that have made it difficult for states to implement. Key among them are the cost-effectiveness test, which means that the cost of providing premium assistance for employer coverage, plus the cost of administration, plus the cost of any needed wrap-around coverage to bring employer benefits up to CHIP levels has to be the same or less than providing those services through direct coverage in CHIP or Medicaid. But in this case, CHIP.

The second issue is on providing the wrap-around services, and there's just a lot of complexity in providing those services as well as determining what services are needed. So just getting information both to determine cost-effectiveness and the wrap-around needs is hard because you need to get a lot of information from a lot of different employers about their numerous -- about their multiple plan offerings that might be available to families. So those are sort of the two big issues.

From a family perspective, it can be really hard

to understand sort of how your premium assistance program works, particularly around getting wrap-around benefits, and even, you know, really just knowing that they're available.

So the point of the presentation was to highlight some of those operational complexities and challenges before states in using CHIP funding to purchase employer coverage. And that is sort of borne out in the state experience in terms of the number of states that actually have these programs. In CHIP, it's really limited. It's just about six states, and enrollment is really like in the hundreds for each of those states. So it's quite low.

So that's the --

CHAIR ROSENBAUM: So I guess my only question is: Is there any reason not to allow states to -- there's nothing to suggest that states that wish to do so should not be allowed to do it?

MS. JEE: No. I mean, I don't think so. I mean, I think it's hard to do --

CHAIR ROSENBAUM: It's just of marginal utility, potentially.

MS. JEE: Yes, yes. And, you know, I think that

there potentially are ways to ease use of premium assistance if the Commission wanted to think about, you know, ways to address some of those barriers, such as the cost-effectiveness test and the wrap-arounds on, you know, benefits and cost sharing. Those would be the key ones.

EXECUTIVE DIRECTOR SCHWARTZ: And also some of the states, instead of putting the burden on the families to do this, are going to the employers to do that and having the employers provide the information to be able to serve the kids of their employees rather than saying, you know, oh, hey, you, you've got coverage, did you know that you could get your kid on that, too?

COMMISSIONER COHEN: I just want to make the point on this one that, I mean, I think the history of this in Medicaid and in CHIP is sort of tortured just because, you know, sort of the tools for doing this have just been so -- I mean, it's just so hard. It's so one at a time. It's so labor intensive. It's so complicated. You're asking Medicaid or CHIP workers with maybe limited sort of knowledge about private health insurance and how it works, you know, to sort of like bridge these programs. Again, this is a place where the environment is changing, but

everyone is still thinking about that past experience. There is more standardization. There's more information that already has to be collected, and I just think we have to really stay focused on that. It's not like it was ten years ago. It's also not -- I'm not saying it would be easy, and I think we probably have to make some actual really meaningful tradeoff to make it really streamlined. And I think those will all be tough questions, but I just really don't want us to get, you know, sort of hung up in the past experience when there's been a lot of policy and operational change since then.

CHAIR ROSENBAUM: So just to wrap up so we can break, do we want staff to further develop for us as part of the work over the summer a relaxation of the cost-effectiveness test and a relaxation of the wrap-around standard, both things, to see what they would cost and whether they would, based on what we know today, whether they would ease the utility of the model?

COMMISSIONER GORTON: So I guess I would say no, in part because the employer-sponsored insurance space is enormously complex, and it isn't getting any less complex. And so if you're writing commercial paper, then you have

thousands of plan variations, and the employers have the right to purchase what they want to purchase, right? So that it is -- and even with all the standardization, we're talking about standardization from tens of thousands to standardization of thousands.

It seems to me that if we want to focus on premium assistance, because we have this national overlay in the marketplaces, that's a place where you have standardized plans with standardized actuarial value and standard benefit packages. My view, if we're going to spend energy on premium assistance, we ought to do it there, and not, you know, spent it on the employer-sponsored -- I mean, ten years from now, we can -- you know, our successors can come back and talk about how to move our successes in the exchanges into the employer-sponsored world, but I don't -- if we take that on, I think it's just an exercise in asking the staff to beat their heads against walls.

CHAIR ROSENBAUM: Well, in fairness, not that we want staff to beat their heads against the wall, but I think the question of whether it makes sense for any state to do this, to waste its time, in your view, doing this, is

a different question from whether we're asking staff -- we're not asking staff to determine the wisdom of doing this at this point as much as whether we're asking staff to think about whether there would be cost implications and, therefore, its degree of importance to us to have the elimination of the cost-effectiveness test and the wrap-around test.

So your point, I think, goes to whether, you know, it's something that a state would want to focus on as opposed to the other form of premium assistance.

COMMISSIONER DOUGLAS: Yeah, and I guess from both -- thinking from a state perspective as well as from the consumer, if -- and the family -- if they want -- I mean, part of the barrier has been the inability to stay with that employer if they can't -- you know, if they can't pay for it. And so the question I still have, I don't think that we can look at all the different benefits, but what is the value from, you know, an outlay standpoint if we let families stay with their employer coverage, even if it meets a lower standard than the CHIP, but that's what they want. So it's the question of is that operationally feasible and what's going to be the fiscal. But I don't

think we're going to -- you know, looking at all the different levels and expecting, that's where it gets impossible to operationally implement. But is there value in relaxing all the entire -- the CHIP requirements to let families stay there and just, you know --

CHAIR ROSENBAUM: Substitute it [off microphone].

COMMISSIONER DOUGLAS: Substitute it, that's the question. And how much is that going to cost? Is that going to cost more or less to do that?

CHAIR ROSENBAUM: All right. Then I think we are -- yes, we have a few minutes for public comment [off microphone]. Do we have public comment?

PUBLIC COMMENT

* MR. HALL: Hi. I'm Bob Hall with the American Academy of Pediatrics. Thank you all so much. This is fun stuff. It's complicated stuff. And certainly the Academy really appreciates your attention to the needs of kids, and it's really great to see folks talking about this to such a deep extent.

I think the child advocacy community has agreed to some degree that no child should be worse off. Right? We're going to have an opportunity to try to talk about

kids' coverage relatively soon. That's pretty much the bottom line.

I would say that the Academy would hope that all children are better off as a result of actions that we can take jointly for them. We were all children once, and so it's important to remember what that's like and to make sure that future taxpayers are going to be able to do that.

The other thing that I think is compelling is there was a discussion about the rights of states, and I think generally pediatricians feel the fierce urgency of now. We need to do good things for children now. It's a very important time, especially in the early years of life. Now is an opportunity to try to improve and continue on this path that we've been on for quite some time, very successfully. We would urge you as part of your vision to think about really what's best for kids. Don't think necessarily about, geez, this might cost X or how could this actually be implemented. Think about what is the best possible result for our children. That is certainly what pediatricians would hope you would undertake, and certainly Congress we think would hope to undertake that as well. We have some opportunities here that are a little different.

Now let me sound a little bit more like a doctors' group. We in discussing the Affordable Care Act went to Capitol Hill and talked about the ABCs for kids -- access, benefits, and coverage. Your Commission's name is the Medicaid and CHIP Payment and Access Commission. There is little discussion from our perspective about access-oriented issues and what you guys discussed today and at other times.

This is important, especially in the context of children with special health care needs, especially in the context of really sick kids. And it's not just about payment. There are real workforce challenges we face in the subspecialty pediatrics realm that's essentially the opposite of what you see in the adult side. So we would really appreciate more attention to what's going on in the real world. We have some real concern about the lack of ability at the Academy to really gauge both payment rates and primary care and subspecialty care access. It's a very challenging issue, and you are better positioned than perhaps any other group to take a look -- maybe even take a look at what's going on in managed care, considering that there are so many kids in managed care at this point.

In terms of two other issues, again on cost, the Congress just undertook about a year ago to pass a law that spent $140 billion off budget to address Medicare access. We did nothing for Medicaid in that context, but we did extend CHIP. The numbers we're talking about in terms of kids' coverage are minuscule in comparison to what we do for other populations in the United States. We would urge you to start thinking about that hopefully a little differently. We need to invest in children. It's a much better way to go.

And then, finally, in terms of premium assistance, we have had not the best experiences with premium assistance in the past. Wrap-arounds especially of EPSDT have been challenging, and we generally look askance at those. But I'm happy to go into that more, and I really appreciate all the work you're doing in CHIP.

Thank you.

CHAIR ROSENBAUM: Thank you very much. And just to note, MACPAC is getting ready to issue four specific issue briefs on children's access, so I just didn't want to -- I wanted to make sure I got the ad in for our issue briefs.

DR. RUSHTON: So I'm Francis Rushton. I'm a pediatrician from Beaufort, South Carolina. I am also a past board member of the American Academy of Pediatrics and have had the privilege for the past six years to be the medical director for the CHIPRA state quality improvement demonstration grant in the State of South Carolina.

I really liked the word "evolution" that I heard around the table as you were talking about children's health care. It's always going to be evolving. And as the only organization that's solely focused on children's health, you have facilitated a lot of that evolution, particularly in the State of South Carolina. With the CHIPRA quality improvement state demonstration grant, we've worked with practices at the grassroots level, over 45 practices across the State of South Carolina. We've achieved some significant cost savings in terms of reducing unnecessary ER usage incorporating preventive oral health services, including dental varnish, into pediatric offices, creating a better arena for the treatment of behavioral health services at the pediatric level rather than at the psychiatric level, to the extent that the cost savings are so real that now that my CHIPRA state demonstration grant

has gone away after its five years of funding, the State of South Carolina has decided to pick up the cost of that program to help us continue to evolve children's health care.

So I think CHIPRA does have a real -- or CHIP has a real role in promoting and facilitating this growth so that we do a better and more cost-efficient job at promoting optimal health and development.

Thank you.

CHAIR ROSENBAUM: Thank you.

MS. LOVEJOY: Hi. I'm Shannon Lovejoy with the Children's Hospital Association. Thank you for the opportunity to provide comments. We join with many other groups that I'm sure are waiting in line to express our support for an extension of CHIP, and we really appreciate that MACPAC has been continuing its work on the future of children's coverage. And we're definitely encouraged by a lot of the comments today.

Our recommendation to you would be to really continue to consider the need for long-term stability for children's coverage programs as you're looking at your recommendation for CHIP. We know that CHIP is a proven

program. It has important cost-sharing protections, provider networks, and benefits that are also offered at a level and frequency that better reflect the needs of children. And we believe that CHIP along with Medicaid will continue to be important sources of coverage for children as work continues to improve alternative coverage options for kids. And we ask that as you're continuing to look at these issues that you really do include the need for long-term stability in the program for families instead of just a short-term extension so that we can maintain proven coverage programs while we are working to ensure that these other coverage alternatives really do address the benefits and the cost-sharing protections in the provider networks.

So thank you very much for the opportunity again, and we look forward to continue working with you.

MS. HERNANDEZ: Hi. Brittany Hernandez with March of Dimes. We'd like to echo the comments of my colleagues before me and likely after me about, you know, thanks for all the work that you've been doing on this. We do need a long-term extension so that we know what the future of the program is.

As you guys have discussed throughout the afternoon, states are in a precarious situation, especially considering the fact that we may not consider the 23 percent bump continuation. If you saw in the Arizona CHIP legislation, when they renewed their CHIP program, they only did so on the contingency that they do have the 23 percent bump, and so we worry that other states could write that into anything that they see down the road.

My last point, CHIP covers pregnancy care for women in 18 states, so that's a third of states; 370,000 women a year get pregnancy coverage through CHIP. It's extremely important. Every state that does it does it for up to 185 percent or higher of the federal poverty level, so it's a really important bridge between Medicaid coverage for women who don't qualify for that. So we just ask that you keep that in mind. It is the Children's Health Insurance Program, but it does provide coverage for pregnant women as well who have children.

So thank you very much.

CHAIR ROSENBAUM: I'd like to just make a note of that for people who may not be totally familiar with this, but, of course, pregnancy is not a special enrollment

period in exchange coverage, and so if you didn't enroll during an open enrollment period and you do become pregnant, your pathways are Medicaid or CHIP. And so I think it's something for us -- we didn't discuss it specifically in the earlier segment, but it's a very important -- another way that CHIP compensates for a national framework that by virtue of being a specific framework for, you know, a very risk pool-driven model of coverage, has -- is carrying a lot of responsibility in the area of pregnancy and maternity care.

MS. HERNANDEZ: And we would very much like to get an SEP for exchange coverage of pregnancy. We are working on that. But in the time being, CHIP is extremely important and so is Medicaid. Thank you.

MS. WHITENER: Good afternoon. Kelly Whitener, Georgetown University Center for Children and Families, and, again, thank you for your attention to this issue. It's clear that you all are just as passionate as we are as we go well over the allotted time for this topic.

Like some of my colleagues have said, I think it's very important that we try to think positively about the direction of children's coverage and try to make

continued improvements. But absent that, we at least want to stick to where we are and have no child made worse off. So while equity is a really laudable goal that we also are working towards, I think we have to keep in mind that in achieving that goal, we cannot make things worse than they are today.

With that in mind, I think for many of us we have a Medicaid and CHIP expertise, and we do not have a private market expertise. They are very different worlds, and I can speak from my own personal experience at trying to delve into the exchanges, how they work. It's eye-opening. So there are a number of things that you would have to consider with the exchange as an option for children. For example, many of the affordability protections in the exchange that we've already discussed and you've discussed are not good enough, are also indexed so they get worse over time, where if you have a child on Medicaid or CHIP today, that is not the case. That is a fixed benefit as opposed to just a fixed financial amount, and that family's share goes up and up and makes things worse and worse.

You have to think about rating rules. You have to think about risk pools, all kinds of things that are

really different than how we have traditionally approached children's coverage in this country. So I just would express the need for a lot of caution in that area.

And then, finally, because of these things, because we want to try to make things better, and in the worst-case scenario, at least not make things any worse, we think that we need CHIP for the foreseeable future. It would be nice to have a longer-term picture and longer-term goals about how we can move things forward for all children so that those million-plus children that are getting coverage through the exchange are getting something better. But in the meantime, we really do need CHIP. And with that in mind, I would encourage you to think very practically about what is coming down the pike in the next couple of years and would underscore the importance of some of the questions that Chris and Joanne raised around the maintenance of effort and really needing to spend some time thinking about that.

We know, for example, in Oklahoma that they are proposing moving all of their kids into the marketplace in 2019 when the MOE expires, and that's without any additional protections for those kids. So there would be a

whole set of kids right there worse off within an MOE extension.

Thank you.

MS. FITZGERALD: Good afternoon. I'm Carrie Fitzgerald with First Focus, a national children's advocacy organization based here in D.C. Along with many of my colleagues here in the children's health community, we did probably close to 200 Hill visits in the last two years to talk about CHIP and CHIP funding. So not that we know what they're going to do next, but I can tell you, you are all very correct when you say CHIP is popular and it is bipartisan. We had very, very positive visits, really. They love the program. There are, you know, differences of opinion as far as how long the funding should be and when, but those were really the only differences we ever talked about in all of those Hill visits.

A couple things I just want to say that we would recommend from First Focus that you continue to think about. I was sitting here next to my boss for most of this meeting. We love the idea of the long extension you are recommending. I think if you did a long extension -- I mean, you recommended and then Congress did a long

extension of anywhere six to ten years. I think you will be -- we will all be pleasantly surprised when we see how states respond to that. There are pent-up ideas in states right now, I think. They're ready to do something. They want to do some more things on CHIP. But the two-year extension sent a signal that made states very nervous. They weren't sure where to go. I think a longer extension, then we'll see some innovation.

The MOE, as Kelly just said, is really important. It's really important that that be continued and that Congress get that message. We would love to see the base eligibility level, federal poverty level raised for CHIP. We would love to see states be able to go up higher. We think many states want to.

A couple ideas just to think about or recommendations to make CHIP stronger right now are things like what if all children in this country zero to five, what if we had continuous eligibility for the first five years of life? What if we lived in a country where no child was uninsured those first five years during brain development? That's an idea to recommend.

Also, what if a child actually had coverage the

day they left the hospital when they were born, not an application in the mail but coverage? How could we do that?

Those are just a couple ideas to throw in. Thank you.

CHAIR ROSENBAUM: Thank you.

MS. HONBERG: Last but not least, I'm Linda Honberg. I'm with Family Voices. We're a national nonprofit organization representing families with children with special health care needs, and I just second opinion to everything that my previous colleagues said.

The only thing I'd like to add is there was discussion about vulnerable children being around poverty, which I agree with. But, really, the canary in the mine are the children with special health care needs. They are the most vulnerable.

So I would urge you to think about that and the impact of your discussions on children and youth with special health care needs, especially getting access to those providers that they need, both pediatric specialists and the children's hospitals. And thank you for a great discussion. You know, I do hope we do get CHIP and also

think about Medicaid and the impact they have on children and youth with special health care needs.

Thank you.

CHAIR ROSENBAUM: All right. Well, I think we are at a delayed break. It's now about 3:05, so why don't we take ten minutes and be back -- we're running well behind, but more really big issues to come [off microphone].

VICE CHAIR GOLD: That was an important subject. It probably should have had more time, anyway.

* [Recess.]

CHAIR ROSENBAUM: Okay. I think we only have the minor issues of long-term care, disproportionate share of payments, and other modest things to deal with in duals. So I'm going to get us back and going, and, Katie, take us away.

REVIEW OF MEDICARE-MEDICAID COORDINATION OFFICE REPORT TO CONGRESS

* MS. WEIDER: Great, yeah. So we're changing gears a bit for the rest of the afternoon, and I'll be discussing our intersections of our work on dually eligible beneficiaries, with the CMS Medicare-Medicaid Coordination

Report to Congress for fiscal year 2015.

The report was published in March, and the Commission is statutorily required to review and provide comments on HHS reports to Congress within six months of their publication. The Commission can use this opportunity to comment on the report and also identify future areas of work for the Commission related to dually eligible beneficiaries.

On our next slide, which will be up in a moment, we provide some background on the Medicare-Medicaid Coordination Office, which I'll refer to as "duals office" for the remainder of the presentation.

The duals office was established through the Affordable Care Act. It's charged with improving care and reducing cost for dually eligible beneficiaries as well as rationalizing the administration between the Medicare and Medicaid program.

During our May 2015 Commission meeting, Tim Englehardt of the duals office gave the Commission an update on their initiatives and specifically focused on the Financial Alignment Initiative.

In its report to Congress, the duals office

highlights its ongoing initiatives and makes legislative recommendations. Some of their initiatives are specific to Medicare, but today we'll focus on the initiatives and recommendations that relate to MACPAC work and also can affect Medicaid. And the three areas that we'll be reviewing are the Financial Alignment Initiative; issues related to the Medicare Savings Program, the MSPs; and aligning Medicare and Medicaid appeals processes and the review of D-SNP marketing materials.

The duals office report highlights the progress of the Financial Alignment Initiative. The Financial Alignment Initiative aims to improve quality of care and reduce spending for dually eligible beneficiaries by better aligning Medicare and Medicaid, assessing a capitated model and a managed fee-for-service model.

Currently, there are 14 demonstration programs across 13 states, with approximately 450,000 individuals enrolled. The majority of states are pursuing a capitated model, and New York State is pursuing two programs under the demonstration. The demonstration was originally intended to last three years; however, CMS has allowed the states to extent the demonstration for an additional two

years.

The State of Virginia, however, has indicated that it intends to ending its demonstration in December 2017 and will transfer dually eligible beneficiaries enrolled in the demonstration into a managed long-term services and supports program.

Plans have also dropped out of the demonstration. Currently, there are 61 plans participating in the capitated model. But six plans -- four in New York, one in Massachusetts, and one in Illinois -- have also dropped out of the demonstration.

CMS has contracted with RTI to conduct evaluation of the demonstration and so far has released two reports to date. The first provides a general overview of the demonstration's program and early experiences in 7 of the 14 programs, and a second evaluation focuses on Washington State's managed fee-for-service model. In the report, CMS found that the Washington demonstration saved the Medicare program about $22 million relative to a comparison group during its first 18 months of operation. However, the Medicare Payment Advisory Commission, MedPAC, has questioned the demonstration's ability to produce such

savings, as costs appear too large relative to the number of individuals served.

Data on Medicaid spending changes and utilization of services are not yet available, and this is largely due to states transition from MSIS to T-MSIS.

So, as you know, MACPAC has been monitoring the status and financial effects of the Financial Alignment Initiative. In 2015, MACPAC conducted a focus group with beneficiaries enrolled in the demonstration in Massachusetts, Ohio, and California. The purpose of the focus groups was to gain an understanding of their early experiences in the demonstration. We presented these findings at our May 2015 Commission meeting. You will recall, in general, most individuals in the focus groups supported the concept and purpose of the program and valued the expanded services they were receiving. However, many focus group enrollees do not have a clear understanding of the demonstration program, reported that they had received confusing information, and had not yet connected with their care coordinator or had received their required health risk assessment.

Following the focus groups, we published an issue

brief and state-specific fact sheets on the overall design of the Financial Alignment Initiative, and we're currently working on updating those.

And although the Financial Alignment Initiative is a large undertaking, we have to note that there are over 9 million dually eligible beneficiaries not participating in the program. It's important to recognize and understand the complexity of their Medicare and Medicaid coverage, and as a result, we're looking at publishing an issue brief that analyzes these beneficiaries' enrollment in Medicare and Medicaid plans to be published later this year.

So this brings us to our next slide on potential areas for Commission comment to their report to Congress, and here, we outline five points for Commission consideration. These areas relate to our ongoing work and interest in the Financial Alignment Initiative, the importance of publishing and producing data on the demonstration, and additional strategies for aligning Medicare and Medicaid.

The next area of the duals office report that we'll focus on is the Medicare Savings Program, the MSPs. Medicaid covers Part A and Part B premiums, and Medicare

cost sharing for certain dually eligible beneficiaries through the Medicare Savings Program.

As you know, states are not obligated to pay the full amount of Medicare cost sharing for dually eligible beneficiaries. States are allowed to pay providers less than the full Medicare cost-sharing amount if a payment to a provider would exceed the state's Medicaid rate for that same service. This is commonly referred to as the "lesser-of payment policy."

The duals office report summarizes a study they conducted on the effects of state use of lesser-of payment policies on access to care for dually eligible beneficiaries. The study found that dually eligible beneficiaries are less likely to use outpatient services, but more likely to use acute care services relative to Medicare-only beneficiaries in states that utilize the lesser-of payment policy.

Additionally, the report recommends aligning MSP income and asset definitions with those under the low-income subsidy, LIS program -- Part D -- excuse me -- Part D low-income subsidy program.

Today, both the MSPs and the Part D LIS program

provide financial assistance to individuals with incomes at or below 135 percent of the federal poverty line who also have limited resources. However, the programs use different income and asset-counting methods to determine eligibility.

In 2015, the Commission discussed aligning MSP and Part D LIS income and asset levels, but identified that additional research was needed on MSP take-up before pursuing the issue further.

This leads me to our next slide on our work relating to MSPs. In Chapter 4 of our March 2013 report to Congress, the Commission described the different MSP programs and documented which states utilized the lesser-of payment policies.

In our March 2015 report to Congress, we built off this work and presented the Commission's analysis on the effects of Medicaid payment, of Medicare cost sharing, on access to care for dually eligible beneficiaries. Our work was similar to the study that was conducted by the duals office and found that lower Medicaid payment of Medicare cost sharing is associated with lower Medicare service utilization among dually eligible beneficiaries

relative to Medicare-only beneficiaries.

In our March 2015 report, we also noted that we would continue examining enrollment into the MSPs, and we are currently undergoing a study to examine the number and characteristics of those eligible but not enrolled in the MSP.

On this slide, we present staff's assessment of two areas that the Commission can comment on issues relating to MSPs. Potential comments include highlighting our ongoing work and interest in the MSPs' enrollment and eligibility.

The final area in the duals office report that we'll focus on are the other two recommendations that they make. The first is to align the Medicare and Medicaid appeals process, and the second is to establish a coordinated review process for D-SNP marketing materials. The Commission has yet to review either of these issues, but we're raising them today as a potential area for future Commission work and further consideration.

As next steps, if the Commission decides to comment on the report, we will take Commission feedback and incorporate it into a comment letter. Once the letter is

drafted, it will be sent back to the Commissioners for final review and comment.

Additionally, staff spoke with Commissioners Gold and Burwell about future work related to dually eligible beneficiaries. One suggestion that came out of that conversation was the value of hosting an expert roundtable on barriers and opportunities to integrate Medicare and Medicaid for dually eligible beneficiaries.

We would also like Commissioner feedback on conducting that roundtable and other ideas for new work relating to dually eligible beneficiaries.

Thank you, and I look forward to the discussion.

CHAIR ROSENBAUM: Thank you.

So questions? Discussion?

Brian? Toby, Brian, whoever wants to lead us off.

COMMISSIONER BURWELL: I don't know. I don't feel strong motivation for reporting to commenting on the MMCO report to Congress. This is the fifth report. They've all been kind of the same. They're not really evaluation reports. They're very kind of PR-oriented reports of all the wonderful things the MMCO office is

doing. There's not a whole lot of depth, and it's very short. It's like 15, 20 pages. There's not much -- if you're looking for kind of in-depth evaluation-type information from these reports, it's not there. So I'm not really sure what the purpose is for us to do a lot of comment on them.

I guess my broader frustration really is that the duals demonstration has been going on for some time, and there's really very little information coming out about this demonstration. And there is a lot going on. So I know that there's a lot of reasons why information is not being produced. There has been implementation issues. There are things that have been slowed down. That's why they extended the demonstration. There's problems in doing the evaluation to getting data from the participating plans, getting the T-MSIS problem. There are lots of different reasons, but I just feel that there is a very interesting and large story to be told here, and it's not being told. There are people in this room who are participating in the demonstration who have a lot of stories to tell.

And I also think this is a huge issue. So given

this is a very high-cost, very expensive population, a lot of room for improvement in terms of new models of care -- and I just don't feel like we're getting the -- the reason you do demonstrations is to learn things, and I just don't feel like it's happening.

CHAIR ROSENBAUM: Is it worth a comment on the things that the Commission feels really should be addressed that could merit more time and attention in this report? Since we are educating Congress about what knowledge it has before it, I'm just wondering based on that comment whether it would be important for us to talk about the things that are important for Congress to know that are not yet known yet, given the parameters.

COMMISSIONER BURWELL: I think we could ask CMS maybe for more specific information around certain issues. I mean, the big one is the opt-out issue. I mean, the real reason why they have the demonstration -- I mean, you can do integrated care models without the demonstration, but the big thing that you get with the demonstration is passive enrollment. Well, even with passive enrollment, there's been very high opt-out rates. Now, there are a lot of reasons for that, and it's varied.

There's no discussion anywhere about opt-out rates, what is the rate by state, anything why they're higher in some states and lower -- you know, that's just one example. There's lots of other areas that we would like to have more information about.

CHAIR ROSENBAUM: Okay. So I have Toby. I have Marsha. I have Sheldon and Alan.

COMMISSIONER DOUGLAS: So, first, I think the idea of getting a convening to figure out the barriers to enrollment is a really good idea. The committee will allow us to highlight some of the things that Brian is just raising now because I think that's the biggest question. We need to keep on highlighting why in states that thought we were going to have three times as many, what's happened, and states know, but it seems not to come out in these reports.

And then that gets to -- I do question if we shouldn't highlight a little bit more about some of the -- especially in the heels of the financing report coming out. I'm a little biased on this, but the areas of the financing where we're looking at Medicaid, the big cost drivers are this population, and yet we're not -- we're still not

seeing the ability to do it. And one of the big reasons then gets to kind of, again, the disconnect between Medicaid and ability to really control delivery reform and Medicare, where you've having just opting out. And there needs to be -- that, without making the policy decision here -- that's the big rub here, and yet Medicaid is where we're looking at the financing. And if we're going to really solve the big financing issue on the Medicaid side, we need to think about the Medicare.

CHAIR ROSENBAUM: So the paradox here is that you made mention about --

COMMISSIONER DOUGLAS: Yeah. I am getting in a little bit too much on policy versus -- but that seems something we could comment on, at least highlighting it, because it gets to Brian's point. And I totally agree, the biggest thing we know is enrollment has not been where we want it at, and we know it's the opt-out. We know it's because we can't really contain people in systems to try value-based approaches for delivery.

I'll stop there.

CHAIR ROSENBAUM: Marsha.

VICE CHAIR GOLD: Yeah. To pick up on some of

the comments, I don't want us to get too focused just on the opt-out because, depending on the state, I think there are lots of complexities in implementation where you put together two programs with rules that contribute to problems.

What I think we might be able to do as the Commission is reiterate the importance of this population and the issues, both from a cost and access-of-quality perspective, and maybe -- I mean, to me, talking about the problems that they've run into isn't a sign of weakness. It has to be a sign of learning, or if they don't learn anything, it wasn't worth anything to do it. And we knew this was tough.

I'm really concerned if there's stuff we could be learning from what CMS already has learned or has gotten from the states, that it seems like there is a real value in pulling that together and analyzing the formative feedback on where really the stress points are, what the problems have been, is it this model, is it other models might be more effective, or is it that it's not the model, but it's trying to get to programs together, or what is it, and encouraging them to make available what is known and to

help us all learn how you can do it, because I don't think CMS should necessarily get a black eye about this if there's been problems -- or the states.

These are hard issues, and it worries me that if we're not learning as much as we might be able to learn about how to do it, there's a real lost opportunity, and it's very important from a policy and a human perspective.

CHAIR ROSENBAUM: Sheldon.

COMMISSIONER RETCHIN: I guess I was curious, since I was -- I had one of the demonstration plans in Virginia when I was there, and I was curious about whether Virginia is really dropping out of the program or they're migrating to a new or different model.

MS. WEIDER: Yes, they are migrating to a different model. They're ending the demonstration in December of 2017 and moving those beneficiaries into their MLTSS.

COMMISSIONER Burwell: So wait a minute. They're implementing the mandatory Medicaid MLTSS, so they have to be enrolled on the Medicaid side. That doesn't say what's going to happen on the Medicare side.

COMMISSIONER DOUGLAS: I thought what they were

doing is they're requiring their plans -- and it's in the RFP -- to require them to have D-SNPs, to have -- so they're almost in essence -- and this gets to another -- you know, the states are saying it's not working, so we're just going to do it outside of the CMS and we'll just say go back to the Medicare Advantage, the D-SNPs, and require it, which is some of the states like Arizona just said they wouldn't do it because of that, and I think Virginia is going down that path just saying forget all the complexity.

CHAIR ROSENBAUM: Use the older model.

COMMISSIONER DOUGLAS: But that's not --

COMMISSIONER BURWELL: So are the MLTSS plans going to be the same as the demo plans? I mean, are they going to -- is it going to be the same people --

COMMISSIONER DOUGLAS: No, there won't be demo plans. It will be -- in essence, they'll be MLTSS plans that are required to have a D-SNP.

COMMISSIONER BURWELL: But what about those people who are already in the demo? Are they going to have to switch plans?

COMMISSIONER DOUGLAS: I don't know the answer on that.

CHAIR ROSENBAUM: We can't have mandatory enrollment. So the question is the uncertainty about the status of certain states needing to know more about some of the evolution that's going on in terms of moving away or actually moving to a more established model which cannot have a mandatory component to it, but [off microphone].

COMMISSIONER WEIL: Yeah, it has been a couple of years since I've been close to this issue, but I just had a little reaction, Brian, to your comments. This is the administration's report, but it's not the evaluation. And so I think I want us just to be careful from an institutional perspective that we're not sort of criticizing CMS for their report not being the evaluation.

CHAIR ROSENBAUM: Yeah, but it's a very good point to keep in mind. I think what I am drawing from the discussion is the comment on perhaps more access to information that the agency might have, understanding that this is not the full evaluation.

COMMISSIONER MILLIGAN: So one comment and one question, both I think related to how this relates to MedPAC, actually.

The comment is if there is a convening of a

roundtable of some sort, I would hope that we would include MedPAC in some form. So I'll just put that comment out there.

The question is related, and it's maybe a question, Anne, to you. I'm not quite sure who to. What do we know about MedPAC's research agenda about the Medicare implications of these demos? Because I do think -- I mean, I'm picking up on Toby's comment. You know, there's this -- duals are the highest-cost part of the Medicaid program. There's a lot of, you know, long-term services and supports in there. There's a lot of frailty and other things, behavioral health increasingly. But a well-managed version of an integrated model helps avoid Medicare costs. It helps avoid ED use, admissions, readmissions, avoidable condition. And I'm wondering what MedPAC's research agenda is on the Medicare side of the duals who are part of all of this.

EXECUTIVE DIRECTOR SCHWARTZ: So we speak with MedPAC frequently, and actually MedPAC is going to have a chapter in their June report, and Katie was a reviewer for that chapter, so I will let her tell you what's in that chapter because my impression is the things that they are

publishing now is sort of their main activity for the moment, and we don't anticipate -- they don't anticipate a lot more after that. So maybe, Katie, you can tell what's going to be in their June report.

MS. WEIDER: Yes, so their chapter is going to be focused on the duals demos. They did site visits to California, Massachusetts, and Illinois. I was able to go -- they allowed us to go on their site visits, so I tagged along on two of them. So they'll be presenting their findings on that. And then they'll also be discussing three scenarios that they presented before on MSP eligibility expansion.

COMMISSIONER COHEN: Just a general point, and I also wanted to reference back to some work that we did at the beginning of MACPAC that I think is relevant. So I've always been -- I feel like when people talk about dual eligibles and programs, you know, integrated programs around dual eligibles, there's often sort of like a conflation of like the bureaucratic issues that make coordination between Medicare and Medicaid hard and like do we know what a good care management model is and how to scale on. And there are two very different issues, and one

complicates the other, but they are different issues. So I just feel like you always have to separate those out when you're thinking about evaluation and what is scalable and doable. One's really about the delivery system, one's really about how do you get two different programs to sort of aim towards the same good delivery system if you know what that looks like and you know how to create it.

And so I think there's been a lot of bureaucratic and sort of financing coordination issues, you know, in the duals demonstrations, but I'm not sure if we've learned anything about whether or not there is a care management model that if you just designed it a little bit better, you could incentivize, that would really work for this population.

And I do go back to -- and I'm going to state the findings all wrong, I know I am, but I am channeling Trish Riley right now. Early on in MACPAC, lacking the ability to really sort of do any analysis of dual eligible spending on both sides of the equation, we did a chapter and some work around disabled dual -- sorry, disabled Medicaid-only beneficiaries and basically found, gee, we have done -- you know, we know very little about what good care management

or sort of -- we haven't -- even when there is no bureaucratic issue about crossing over two programs for a population that is totally within the control of one program in one state, we have definitely not tackled effectively how to manage a population in the delivery system that we have.

So I just always feel like that's an important framing point because it's very easy to point to the challenges of coordinating two programs, but I actually think the challenge is a lot deeper for many of these populations. We just don't know how to take care of them efficiently in the delivery system that we have.

EXECUTIVE DIRECTOR SCHWARTZ: I just want to interject there. I don't disagree with the main point that Andy was making, but I want to just clarify that we do have a joint --

COMMISSIONER COHEN: Thank you.

EXECUTIVE DIRECTOR SCHWARTZ: -- data set that we have developed with MedPAC to do our data book that we've been doing with them for several years running. It shows the patterns. It obviously, to your point, Andy, doesn't tell you how to fix them, but we do have the ability to --

COMMISSIONER COHEN: Right, and all I was saying is that early on we did --

EXECUTIVE DIRECTOR SCHWARTZ: We can do that now, but we still haven't figured out the next part.

CHAIR ROSENBAUM: And is there anybody in the audience from MedPAC who can just follow up on this question of the June report? Yes.

MR. ROLLINS: What was the question?

[Laughter.]

CHAIR ROSENBAUM: So the question --

EXECUTIVE DIRECTOR SCHWARTZ: What are you up to that you want to make sure that we know --

CHAIR ROSENBAUM: Exactly. What can we expect to see? And how is that -- it would help us inform our own [off microphone].

MR. ROLLINS: Hi. By the way, my name is Eric Rollins. So we will have a chapter in our June report, as Katie said, reviewing what we have found from site visits. We are planning to conduct some additional site visits in the coming year, and we're hoping to get some enrollment data from CMS as well to start looking into some of these enrollment patterns that you're seeing for the

Medicare/Medicaid plans. But in terms of sort of concrete next steps, I think we're sort of a little bit hamstrung by the limits on the data that's available so far. So we are, like you guys, looking to see what CMS starts putting out some evaluations.

COMMISSIONER BURWELL: Can I just ask the depth of the site visits that were conducted? Was there a very broad range of stakeholders interviewed during the course of the site visits?

MR. ROLLINS: We did try to talk to a broad range of stakeholders as part of the site visits. I think across the three site visits in total we conducted about 40 interviews.

COMMISSIONER BURWELL: So providers, plans --

MR. ROLLINS: Correct, beneficiary advocates --

COMMISSIONER BURWELL: -- et cetera.

MR. ROLLINS: State officials.

VICE CHAIR GOLD: Yeah, I would just caution us -- or thinking about what's useful, there's a natural tendency to be looking for the data that said did this work and what are the costs, say. And, obviously, we'd like to have that. But given Andy's point and some of the other

points, we don't really know what models there are. So if it doesn't have an effect, we don't know if it's because it wasn't implemented, it wasn't implemented well, or it wasn't done something else.

So I think if this is the traditional CMS evaluation, and MACPAC does some of that, and MedPAC does some of that, the process stuff about what happened, what didn't happen, trying to figure out to what extent there were barriers to implementation, what got done, was there diversity. Were there some plans that could do it well and what distinguishes them? Are there some market characteristics or state characteristics that make it easier? That's really important evidence. And I suspect some of that data are there now, so I guess I'm less focused on just finding out what the impact study will show, because I don't think it's going to help as much as we think, given we know there's all these other things going on.

And, Brian, if you disagree with that, feel free, because you're closer to them than me.

COMMISSIONER BURWELL: No, I want to hear what Kit has to say, too.

COMMISSIONER GORTON: So in light of our new policy, let me be transparent to the Commission and the audience that I operate an MMP, and I'm one of the two remaining Massachusetts -- work for one of the two remaining Massachusetts plans in the demonstration. And we are in the 30th month -- I'm sorry, the 34th month of a 39-month demonstration, and we have just entered into negotiations with our counterparties in the agencies about the offer of a two-year extension. And so I'm not going to talk about anything that might impact on that.

But to the point that has been made about opt-out, and people have said, you know, we shouldn't focus just on opt-out. And I agree that opt-out is one of a variety of learning opportunities that we have in the demonstration. But the demonstration has shown in high relief and as far as I know, having seen reports from a variety of markets, pretty uniformly the opt-out rate in this program is substantially higher than anybody has ever experienced in any other program.

And so, on the one hand, you have focus groups being conducted -- we've done ours; I'll quote ours rather than other people's -- in which the member advocates are

wildly favorable about the program. And yet you have enrollment decay rates that give you a half-life of -- in our oldest cohort, the enrollment half-life is -- we will have lost 50 percent of the original members over the course of 36 months. And if we look at the more recent cohorts that have come in, we're looking at a half-life of about 18 months.

So I think that there is a fundamental question that we could answer now, and we don't have to wait for RTI, which is to try and figure out why people who leave and get into the program don't want to stay in the program, because we may all think that this is a good program for them, and I can talk about why it is and why it isn't, and my organization's point of view is that we do think it's a worthwhile endeavor and we engage people in a model of care, which we do think we've learned a bunch about, that we can actually create value for them and value for the system. But what we face is that they don't stay in the program.

So what don't they like? And I think it's fair -- hopefully my friends in the agencies won't object to my saying this, but that's why I disclosed my conflict right

here. You know, I think everybody would agree that none of us know why it is that when after sweating blood and, you know, banging on doors and chasing people down through all variety of means, you get them into the program, why they don't stay. I don't think anybody knows the answer to that. And so I wrote in a blog piece for AHIP -- it was published last week -- that dealing with the enrollment issue, particularly in a circumstance where the Medicare component of it cannot be made mandatory, figuring out how to make that work is one of the fundamental challenges confronting the demonstration. It doesn't do any good to enroll a million people if 36 months later you only have 250,000 left.

CHAIR ROSENBAUM: So can I ask a basic question here, which is, are we writing a comment letter to CMS or are we simply asking for more information from CMS? There's sort of a difference here between the two. I mean, what we're expressing is the frustration of certain -- a feeling that we should be knowing more now than we know, and worrying that there's information that we could have, although it's not clear that there's information or whether there's just not information until the evaluation is done.

But I think one is a public comment on the report, and one is simply an exchange between the staff and CMS staff about, you know, what can we get more of that we don't have today.

COMMISSIONER GORTON: So my answer to that is I see -- as Brian said, these reports are required by Congress, and CMS is dutifully sending them in. They're saying what they're prepared to say for public consumption at this point, and I think commenting on that in my view is probably one step higher than Kabuki theater. And so I'm not sure that that's worth the staff's investment of time.

I do think you could talk to CMS about what's available. I think the struggle for them -- and I'm not in a position to speak for them, but I think the struggle for them is MACPAC, like MedPAC, does its business in public. And we're making sausage here, and they're not ready to be out on center stage with the sodium lamps and everything else and to be defending what is, in fact, a very valuable learning opportunity that is still very much in flight.

COMMISSIONER THOMPSON: Can I just follow up and ask Kit what you think about -- because it seems to me that there's one reasonable set of questions that really does

inform our work in a very significant way, which is when do we think we can expect to receive certain kinds of information? What is CMS' plan --

COMMISSIONER GORTON: It's my understanding that CMS has in hand the first of the RTI reports on three demonstration states; they're reviewing them. And it is my understanding that they would anticipate in the normal course of business to be releasing those sooner rather than later.

COMMISSIONER THOMPSON: And do you think those are going to be -- given kind of the timing of all of the demonstrations as they've worked out, are going to provide us kind of as much as can be known today around some of these questions, in particular around the reasons for beneficiaries opting out over time from --

COMMISSIONER GORTON: I --

VICE CHAIR GOLD: Did they do disenrollment [off microphone]?

COMMISSIONER GORTON: I don't know the answer to that.

COMMISSIONER THOMPSON: Okay.

COMMISSIONER GORTON: To Marsha's question.

Penny, to your question, what you're getting is the first generation of reports which are being done to meet the very high standard of the health policy research world. So I think you're going to find from a practical point of view they're going to be heavily caveated. You're going to find methodological issues. They are in many ways dependent on claims data, which -- you know, so you're going to be looking at year-old data. And at least in the context of Massachusetts, you're going to be looking at -- you're going to have a small numbers problem as well.

So I suspect that for the analysts in the room, the reports will be less than satisfying. That's CMS' justification for the two-year extension period, is to not have to abort the demonstration before they get the next generation of reports.

So, you know, I think what they will say is we're giving you what we have as soon as we have it, and, you know, the question is: Are there some things in -- you know, could we create a forum whereby some groups of people could look at stuff, maybe MACPAC staff could look at stuff, MedPAC staff could look at stuff, you know, sort of in parallel to the formal evaluation process going on?

The issue with that is you all will have more questions, and I can tell you that the plans are feeling -- and states, are feeling examined every which way from Tuesday. It's a challenging program to run. And when you layer on two or three data calls a week on top of that, plus focus groups and surveys and all the other things, you know, I think it's challenging. People want to know what's going on. It's an important program. But, you know, the standards that people will expect will cause folks who have initial impressions about things are going to want to wait until the numbers are, as the actuaries like to say, fully mature.

CHAIR ROSENBAUM: Yes. Toby. And then I think we need to move on to Community First Choice because we still have DSH to go, and so do I hear -- and Brian too. Do I hear a general inclination toward a letter commenting on the importance of the data and what might we expect and what we don't know or just simply not a response and an informal request for data or an update on when data might be expected?

COMMISSIONER DOUGLAS: I mean, I again think that given that this is the high-cost population, I think we

should say something.

I was going to say that I think there are also -- there are state-by-state evaluations, I think, or at least in California, the SCAN Foundation has funded. We consented around the link, but there is evaluations already that have gone on, on a state level. And that maybe is something, instead of just compiling what is going on, what are those evaluations, if more than just California has done it? But that's got some key findings and very positive consumer -- those that have enrolled --

CHAIR ROSENBAUM: Yeah.

COMMISSIONER DOUGLAS: -- have very, very positive perceptions of it, and I don't know about that. I mean, I think I need to get back, but I don't feel like it's been that level of attrition that Kit was saying in California. But looking at those state by -- rather than creating new work, I totally agree with Kit. But have there been some states that can be more brought to light?

CHAIR ROSENBAUM: And maybe as a formal request --

COMMISSIONER DOUGLAS: Yeah.

CHAIR ROSENBAUM: -- from the Commission, given

the importance and the significance of this population.

COMMISSIONER DOUGLAS: Yeah. And not put it on CMS because I don't think they're going to be able to do that, in that role, which is kind of where they are. But we could maybe have staff say this is the research that has been done state by state and what do we know from those today.

CHAIR ROSENBAUM: Okay. Brian, why don't you --

COMMISSIONER BURWELL: I have one final area for which there is almost no information. It's just the whole financing of the program and the impact that it's had on plans. This is an initiative to offset risk for this population to private contractors.

The one report that CMS has issued, "Oh, we saved all this money in Washington State," blah-blah-blah. You read newspaper articles about other plans losing their shirts on this demonstration or dropping out. I talked to one plan. Part of it is like, "They assigned us all these duals. We can't even find 25 percent of them." These are people that haven't had strong connections to the health care system. I'm just saying there's a huge story to be told here, and I just feel like I'm starving for

information.

CHAIR ROSENBAUM: Let us proceed, then, with crafting a letter and thank you.

Now can we move to Community First quickly?

REVIEW OF HHS REPORT TO CONGRESS ON COMMUNITY FIRST CHOICE

* MS. VARDAMAN: Good afternoon, Commissioners. Similar to Katie's presentation, I'm going to be presenting you with an opportunity to provide comments on a report from the Secretary to the Congress, this time on the Community First Choice program.

I'm going to start with a little bit of background on the Community First Choice option, or CFC option, and then I'll provide a quick review of some of the key findings from HHS's recent report to Congress and then outline a couple of areas for potential MACPAC comments primarily based on the Commission's prior work.

As you are all well aware, Medicaid programs have a variety of authorities under which they can provide home- and community-based services to beneficiaries. The Community First Choice option is yet another one of those strategies and was created under the Affordable Care Act.

It allows states to offer personal attendant services to beneficiaries who require an institutional level of care under the state plan, and it's unique in its focus compared to some of the other options. And it's focused on self-directed care and the institutional level of care requirement.

CFC includes a variety of services. Chief among them are attendant services for activities of daily living, such as bathing and dressing, and incremental activities of daily living like meal preparation. It also includes coverage for habilitation services to help beneficiaries improve their own ability to conduct those tasks, and beneficiaries who are engaged in self-directed care, who have more ability to hire and manage their own attendants, can also receive training on those kind of personnel aspects of that program.

And for those Community First Choice services, it does provide an additional enhancement or match of 6 additional percentage points.

So HHS has submitted two reports to Congress, as required by statute and the final report coming in December of 2015, and this report covered the four states that had

approved state plan amendments for the CFC as of the end of 2014. And in fiscal year 2014, those states have served about 307,000 beneficiaries through the CFC option.

The evaluators also interviewed some states that did not choose to participate in the CFC option for their insights on what some of the disadvantages might be of the strategy.

In terms of the key findings, first, I'll start with a little bit about the advantages and disadvantages from the states' perspectives that were in the evaluation report. In terms of the advantages, some states saw that it was an opportunity for them to consolidate some existing waivers that they were providing under different Medicaid authorities prior to the CFC being available and also the enhanced federal match being an incentive.

In terms of disadvantages from those states who did not participate, some felt that there was less flexibility under the CFC compared to some other long-term services and supports initiatives like the Balancing Incentive Program, and they also were undergoing a variety of other initiatives at the same time, such as the Financial Alignment Demonstrations. And so there were some

constraints on administrative capacity that were other reasons why they chose not to participate.

In terms of the findings on health and service use, the statute did require that this report include that; however, given again the timing of claims data availability, really the information that was available was for the pre-CFC period, and so the evaluation report focuses on baseline information, including information on emergency department use and potentially avoidable hospitalizations. They found that there was some room for improvement in helping to achieve better outcomes for this population.

Another concern of states was about the capacity of home- and community-based service providers, particularly in rural areas which had implications for their ability to have adequate backup plans for beneficiaries when case services were missed, which was another requirement of the CFC that they have those.

In terms of areas for potential comments, I outlined two here that are based on prior work. First, in terms of functional assessment tools, the regulations stipulate that states are required to have assessments that

include needs, strengths, preferences, and goals. But in the evaluation report, some advocates, particularly some from the community for individuals with developmental disabilities, said that some of these state CFC assessments do not place enough focus on beneficiary strength and goals and were too deficit focused.

Given that the Commission's June report does include a chapter on functional assessments, this comment letter could be an opportunity to reiterate the statements made in that report about the importance of reflecting the various needs of LTSS users in the assessment tools that are used amongst various state programs.

In addition, as was discussed in the last session, issues around data availability are an area the Commission has made a number of different statements in the past. This report demonstrates again the limitations of the data availability and timing, and so the Commission could again reiterate the need for consistent and timely data to support oversight and policymaking.

So, with that, I will end this presentation and welcome any comments you have in terms of comment letters as well as any other work that we could be doing to look

more broadly at authorities for providing home- and community-based services. Thanks.

CHAIR ROSENBAUM: Great. Thank you so much.

We have Alan, Brian, Toby.

COMMISSIONER WEIL: I have a very simple comment. Again, as a newcomer and the conversation we just had about the last report and thinking about who is our audience when we write these letters -- and we're writing them to Congress to comment on a report, and it does seem to me that focusing more of our attention on the linkage between what's in here and our work and what they can expect to hear from us as we continue our work, as you mentioned, around functional assessment, those kinds of things, I can get much more excited about than sort of taking on the agency, although obviously if there is a report out there that runs strongly counter to positions we've taken, I would hope we would do that.

But it does seem to me in just thinking about our role institutionally to take advantage of these opportunities in a more positive way, to talk about the contribution we want to make would be something I would be supportive of.

CHAIR ROSENBAUM: Brian.

COMMISSIONER BURWELL: So, to me, the question in regard to the role of MACPAC, this is an area where I'd say there would be potential for getting into policy more than just commenting on a report because my reaction to the Community First Choice program is, Why is there a need for this program? It doesn't really -- so my question is, What does it really do? It gives certain states like California the opportunity to refinance. It gets 6 percent more for what they're already doing, and if you look at the actual report, that's basically what the states have done.

This was a program that was largely advocated by the disability community that wanted the -- you know, "Why do we need all of these waivers? Why don't we just make it part of Medicaid?" So they went hard on that, but they didn't get what they wanted. They only got half a loaf. They didn't get the full eligibility that you can get in the waiver programs, and they didn't get the benefit package. So what you've ended up with, as it comes out on the report, is states run this program, but they have to run the waiver programs along with them for the people who aren't eligible for this program and for the additional

services.

And if you just want to do personal attendant services, you can do it under personal care option. So why do we have this program?

I don't know if that's -- are we overstepping our bounds there? I mean, is that our role here? I don't know. I'm a newbie, and it's potentially putting us in a more controversial position.

CHAIR ROSENBAUM: Leanna, did you have your hand up? Let's come back to that. I've got Brian, then Toby, and then Leanna. Yes, Toby.

COMMISSIONER DOUGLAS: Well, I didn't have it, but I gave Kristal some comments on this, and it's really just in line with what Brian said. I mean, this was just a -- unfortunately, in the view of California, this was just a cash transaction and how to implement with doing very little different. And then you have just complexities, huge complexities of all these different waiver and state plan programs and trying to overlay them, and then, you know, a broken record, managed care. This is a total different game in managed care. It's really stepping back of what are we doing with CFC and all these other things

when we're talking about a different world for the most part of MLTSS and managed care, but I don't think there's a letter really for saying that. But it's just the whole thing.

There's a history about why CFC happened and states went with it, but it's not necessarily something to really learn on.

CHAIR ROSENBAUM: Leanna.

COMMISSIONER GEORGE: Well, I can't really speak to why North Carolina did not go with this, but coming from a state that we have for our HCBS waiver, the in-home community supports waiver, we have a seven-to-ten-year waiting list. I could possibly see where this could be a way of providing states an opportunity, without giving that individual a full waiver, with all that goes with it, some support in the home and community. Now, whether or not that is what was going on, I couldn't tell you, but coming from a situation where some families are facing either give up my job because I have to take care of this individual with a disability, put them into an institutional care, which is far more expensive than the waivers or this would be. It would weigh in a whole lot of different issues and

concerns when we're trying to provide for that individual, and there's a lot of other issues or a trickle-down effect that affects the economics of everything, as I'm sure you are all aware of.

CHAIR ROSENBAUM: And so the point you raise, which sort of is a variation, a variation on the very important points that we're making, is that we're asking, so sitting here asking ourselves existential questions and thinking about the very good reasons why something like this should exist, although acknowledging at the same time that it turned out not to be the thing that people really wanted here.

And, of course, what at least to me is somebody who has only limited knowledge of this dimension of Medicaid, I'm thinking that what I'm not hearing is comments on the letter, per se, but a deeper thinking about what do we do as the Commission around broadening long-term services and supports and thinking about how this combination of tools in the toolbox, does it add up to what it needs to add up to or not. And that's a little different from a comment letter.

Chuck, I think you were --

COMMISSIONER MILLIGAN: Yeah. My apologies. I had to do a work call and sort of missed, Kristal, your presentation, but I was prompted to speak because I was the Medicaid director in Maryland when we did do the CFC program. And I want to respond, I think, Brian, to your comment about what is it and why is it any good, and it picks up, Leanna, on your comments.

We had a series of HCBS waivers. We had various personal care in each of them. They all had slightly different payment rates for personal care. Sometimes it was an hour; sometimes it was 15 minutes. They all had slightly different criteria for who could provide personal care.

The enhanced match helped a lot, and the consumer majority advisory board helped a lot, because what we ended up doing was pulling all of that out of the waivers, putting it in the state plan, normalizing all of the criteria about quality, qualifications for attendance, rates for attendance, so we didn't have one waiver competing with another waiver for workforce because we pay better; therefore, it's going to be this waiver who is going to get access. So the enhanced match enabled us to

normalize the rates at a slightly higher rate than a weighted average without the enhanced match. It allowed us to put in the state plan where it's an entitlement and unlike the waivers with waiting lists. And it created a consumer -- and consumer-consumer, Leanna, like you, it's not professional advocates. It's participants.

So I don't think this is necessarily the place to talk the policy part of it, but I did want to weigh in on this existential question because there are a lot of, at the ground level, benefits of what CFC brought to Maryland.

COMMISSIONER BURWELL: Do you have a waiting list in Maryland?

COMMISSIONER MILLIGAN: For the waivers, there are, but the waivers now -- but attendant care isn't in the waivers, so not a waiting list for attendant care. It's for all of the other supportive services.

VICE CHAIR GOLD: So it's not just payments. It's access as well, getting providers and quality of care.

COMMISSIONER MILLIGAN: And it enabled -- so one waiver might have had a $10-an-hour equivalent. One waiver might have had a $14-an-hour equivalent. So we did a weighted average. Let's say it was 12 across all the

waivers. We used some of the enhanced match to raise that payment rate, normalize it, and some of the enhanced match was because of what we anticipated the pent-up demand to be, once it was an entitlement. And so there were a lot of actual value coming. It wasn't just refinancing is the point I'm trying to make.

CHAIR ROSENBAUM: Yeah. I mean, the point you raise, which I think is an incredibly crucial point, not just for this, but for so many things that we discuss in MACPAC, is that often -- and it may be worth a comment, actually, that oftentimes an evaluation, despite its best design, may miss some of the most important reasons why you create flexibility for states. There are questions that we want to have answered in an evaluation, but that having certain kinds of flexibility built into Medicaid, achieves goals that are often deeper aspects of the Medicaid program, and how should states normalize the operation of Medicaid for the greatest number of people? And that may be a very different question from just what did in terms of service outcomes or cost efficiencies, what did this particular state option produce.

We might want to use some of what Chuck just

raised and put on the table as, in fact, a comment to Congress about the importance of flexibility options that don't necessarily translate directly into a giant redo of a program, but may help Congress understand why broadening the handles that states have to work with can be a very productive thing and can help states achieve efficiencies that move them away from 91 different waivers and inconsistent eligibility standards, et cetera, et cetera.

Yes, Norma.

COMMISSIONER MARTÍNEZ ROGERS: Just one comment. Going on what Leanna was saying about sometimes if you don't have someone to help you, you may not be able to go to work. Based on what Chuck was saying, I think that one of the things that we have to look at also is that perhaps it's something that is culturally appropriate for some cultures to have this type of a program. And I think that that is something that we rarely talk about here, about what is culturally appropriate. And I know in a Latino family, we'd rather have someone at home than somewhere else. And I'm sure you also, you'd rather have someone at home rather than institutionalized.

COMMISSIONER GEORGE: Definitely.

CHAIR ROSENBAUM: So, Marsha, why don't we give you the last comment?

VICE CHAIR GOLD: Well, I guess I'm just trying to think if this is the best example to use to write a letter to Congress on state flexibility, because it's kind of messy and all these things add to the complexity of the program and administrative costs. And it may be better to save that point for something that's a little less messy, or limited. I mean, it's really that it's a limited thing. Chuck gave some good reasons why one state may do it. I don't know that we want to be on record as suggesting the whole Medicaid program let everything be up for grabs because there may be some state that would find it useful in some ways. I mean, there has to be some rhyme or reason as to where you do allow flexibility and where you don't, and then maybe another occasion where we can make the point about state flexibility a little better.

CHAIR ROSENBAUM: Yes, I mean, I should note that to the extent that what the HHS report says is that this ended up putting constraints on states, what we have just heard is precisely the opposite.

VICE CHAIR GOLD: Right.

CHAIR ROSENBAUM: And so the question is whether we want to add an observation so that Congress knows that putting some enhancement -- I mean, in the end, this was putting some enhancement out there and giving states an extra tool that people with disabilities, you know, felt, justifiably so, they seriously needed. And to the extent that the report's sentiment is this didn't work, or that's the way you could read it, or it just ended up really tying states' hands and not giving people what they needed, that might be the wrong takeaway message.

So that's the reason why we might want to add not in counter to it but sort of an augmentation point that there's a dimension that the HHS report did not capture that Congress might well, you know, benefit from understanding a little bit more.

Okay. Well, thank you. So now we are up to the small matter of our work on DSH payments, because we knew that you would need something to wake you up at the end of the day here. Rob, you're amazing to plunge into this now.

NEXT STEPS FOR MACPAC WORK ON DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

* MR. NELB: Last but not least. Thanks so much,

Sara.

Again, last but not least, I'm here to talk about our next steps for MACPAC's work on disproportionate share hospital payments, commonly referred to as DSH.

For those of you who didn't have the fun of being here for our first DSH report, I'm going to just begin with some brief background about DSH and the data elements that MACPAC is statutorily required to provide.

Then I'll review some of the findings from our first report on DSH, really focusing on the Commission's conclusion that DSH payments should be better targeted to the states and hospitals that need them most.

As we look forward to our work for the 2017 report and beyond, the Commission has the opportunity to build on its prior analyses and really explore what it means to better target DSH payments. And so to get us started, I'll be outlining some targeting questions for the Commission to consider and highlight some data analysis that we're doing to help inform those questions.

Finally, I'll conclude by discussing some potential federal policy approaches that the Commission may want to consider to improve the targeting of payments.

First, some background. I'll go through this quickly since I know we're short on time. DSH payments, as you know, are Medicaid payments that help offset uncompensated care costs for Medicaid and uninsured patients. In 2014, Medicaid made about $18 billion in DSH payments to hospitals. States are statutorily required to make DSH payments to hospitals that serve a high share of Medicaid and low-income patients. These are known as deemed DSH hospitals. However, states have the flexibility to make DSH payments to virtually any hospital in their state.

The total amount of DSH funding to a state is limited by federal DSH allotments which are scheduled to be reduced beginning in fiscal year 2018 by about $2 billion, which is about a 16 percent reduction. These reductions were initially scheduled to take effect in 2014 under the ACA but have been delayed several times, and with the delay have become larger reductions now for future years. The amount of reductions increases each year, and by 2025, DSH allotments are scheduled to be cut by more than half.

As part of one of the pieces of legislation that delayed DSH allotment reductions, Congress asked MACPAC to

report annually on DSH allotments and their relationship to the factors listed here, and more information about this is in your materials. MACPAC's first DSH report was published in February of this year as a stand-alone report, and then beginning next year, in 2017, this data will be part of MACPAC's annual March report to Congress.

In MACPAC's first DSH report, we found little meaningful relationship between current DSH allotments and any of the factors that Congress asked us to consider. We found that DSH allotments vary widely by state and are largely based on historical state spending from more than 20 years ago. We also found that those deemed DSH hospitals, the ones that are required to receive DSH payments, only received about two-thirds of DSH funding.

In light of these findings, the Commission concluded that DSH payments should be better targeted towards the states and hospitals that both serve a disproportionate share of Medicaid and low-income patients and have disproportionate levels of uncompensated care. And the pending DSH allotment reductions make this targeting particularly important because with less DSH funding available, it's even more important to target the

remaining dollars to the hospitals that need them the most.

Now, to help inform approaches to improve the targeting of DSH payments, the Commission made a recommendation in its first report that HHS collect and report hospital-specific data on all types of Medicaid payments as well as data on the sources of non-federal share necessary to determine net payments at the provider level.

Complete data on Medicaid hospital payments is important for a number of reasons, but for Medicaid DSH, it's particularly needed to understand Medicaid shortfall, which is one of the types of uncompensated care that DSH is supposed to pay for.

Now, although our recommendation hasn't been implemented and we don't have full data on Medicaid hospital payments, there is still a lot of analyses that we can do with some of the data that we have, and I'll talk more about this later.

So, again, as we look forward to explore approaches to better target DSH payments, there are a number of questions to consider, which I tried to break down into three parts based on the Commission's prior

statements.

So first is the question of which hospitals are the ones that serve a disproportionate share of Medicaid and low-income patients. Then there's the question of which hospitals have disproportionate levels of uncompensated care. And, finally, think about it as sort of like a Venn diagram: which hospitals meet both criteria and, thus, should be targeted for DSH funding? I'll explore each of these in a little more detail.

To begin, when identifying those hospitals that serve a disproportionate share of Medicaid and low-income patients, there are number of questions to consider. First is how Medicaid and low-income utilization should be measured. There's currently a bunch of different utilization measures that are used for DSH, and there's some more information in your materials, but they tend to differ in some important regards, such as whether or not outpatient services are included, and then also whether or not they include individuals who are dually eligible for Medicare and Medicaid, since Medicare normally pays for the services in hospitals, but they are still Medicaid patients.

Second, once you have a measure of utilization, is the question of whether there should be a minimum utilization threshold for DSH hospitals. So currently the statute has a 1 percent Medicaid utilization threshold, which virtually all hospitals meet. Other standards that could be used included the "deemed DSH" threshold, which is higher. There's information in your materials. Basically there are two ways that hospitals qualify as deemed DSH hospitals: a Medicaid utilization rate that's one standard deviation above the mean, and the other is a low-income utilization rate above 25 percent. And only about a third of DSH hospitals meet that standard.

And then, finally, since states that have expanded Medicaid have more Medicaid enrollees, those hospitals will have higher Medicaid utilization rates, and so there's just questions about whether or not that should factor into whatever threshold is established.

Second, to identify those hospitals with disproportionate levels of uncompensated care, there's also the question of how uncompensated care should be measured. Currently for DSH, uncompensated care is defined as the sum of Medicaid shortfall -- it's the difference between

Medicaid payments and costs -- and unpaid costs of care for uninsured, which includes both charity care that hospitals provide for free or at reduced cost as well as bad debt, which hospitals bill the patients and expect to receive but do not.

Once we've defined uncompensated care, there's then the question of how much uncompensated care DSH payments should cover. Currently, Medicaid DSH payments cover about half of hospitals' uncompensated care, which may be too much or too little.

And then, finally, again, thinking about expansion, there's the question of whether DSH should be paying for the uncompensated care costs that could have been covered under Medicaid expansion. We know states that have not expanded Medicaid under the ACA have higher levels of uncompensated care, but it's not clear whether they should have higher DSH payments as a result.

Finally, as we sort of piece this together and try to identify those hospitals that should receive DSH payments and those that should not, there are some additional targeting questions to consider.

First is the question about how DSH payments

should relate to the adequacy of regular Medicaid payment rates to hospitals. I would point out that if a state has high regular Medicaid payment rates, then a hospital with high Medicaid utilization may not necessarily have high levels of uncompensated care.

Second is the question of how DSH payments should relate to other supplemental payments that Medicaid programs make, which we refer to as non-DSH supplemental payments. In 2014, Medicaid spending on non-DSH supplemental payments was actually larger than Medicaid spending on DSH payments. And so it just raises questions as we look at ways to target DSH payments, some of these also apply to the non-DSH supplemental payments as well.

Finally is the question about how Medicaid DSH should relate to other sources of direct and indirect support for hospitals. I highlight two in particular: Medicare DSH payments, which also support hospital uncompensated care based on a national Medicare formula, and then the community benefit requirements for nonprofit hospitals that the IRS imposes to maintain their tax-exempt status.

All right. So those are some of the questions,

and I look forward to your feedback about others to consider. To help inform some of these questions, we're working on compiling several new sources of data and updating the data that we already have.

In terms of Medicaid and low-income utilization, we're looking to update our information with sort of post-2014 data, and we're particularly looking at refining our estimates to better account for those individuals dually eligible for Medicare and Medicaid.

In terms of uncompensated care, this year we're excited that we now have Medicare cost report data for 2014 for most hospitals, so we can say a lot more about how the ACA is affecting hospital uncompensated care, patient mix, and overall hospital finances.

And then in terms of looking at other sources of hospital financing, we've begun to compile these community benefit reports reported by nonprofit hospitals and have been linking that to the data that we've been collecting from other sources. So there's a lot to learn there.

Finally, to help kind of complement and provide some texture for all this quantitative data that we're collecting, we're also beginning a project with the Urban

Institute to profile a range of DSH hospitals from expansion and non-expansion states, to provide a little more context and texture about the role of DSH in hospital finances and also the role of DSH hospitals in their communities. So look for more of that to come this fall.

All of these analyses we hope will provide a backdrop to support the Commission's discussion and exploration of potential federal policy approaches to improve the targeting of DSH funds. This slide outlines three potential policy approaches that were mentioned in our first report.

First is to think about, you know, as the DSH allotment reductions take effect in 2018, which will be soon after the Commission's 2017 report, so it's just around the corner, the Commission could propose to change the formula for distributing those potential DSH allotment reductions to help target them towards the states that need them -- larger reductions on the states that need the DSH payments the least and smaller reductions on the States that need those payments the most. The Commission could also decide whether to comment on whether the size of the pending DSH allotment reductions is appropriate.

As part of our first report, we've developed a model to sort of simulate the effects of DSH allotment reductions, and we can adjust this model to simulate different policy parameters that you'd like.

Second, the Commission could propose to raise those minimum eligibility requirements for DSH hospitals somewhere above that 1 percent Medicaid utilization threshold, and with some of the new data we're collecting, we can also simulate the effects of higher utilization thresholds or other standards that you'd like to consider.

And, finally, the Commission could consider whether or not to change the Medicaid DSH definition of uncompensated care, which would help to better target DSH funds to the hospitals with the uncompensated care that the Commission feels that DSH should be paying for. For example, we could model the effects of removing Medicaid shortfall, bad debt, or those uncompensated care costs that could have been covered under Medicaid expansion.

We could also model the effects of expanding the Medicaid DSH definition of uncompensated care, but I would just note that this wouldn't do much to change the targeting of DSH payments since it would simply expand the

amount of things that DSH could pay for.

So as we move forward with this work plan, we welcome your feedback about the questions and approaches presented here and whether there's some additional information that you'd like when I come back to you in the fall with updates. We plan to have a draft of our report in December so that it will be ready for the March report.

Thanks for your attention, especially late in the day. I look forward to your feedback and am happy to answer any questions you may have.

CHAIR ROSENBAUM: So let me start the list going. We have Sheldon, we have Gustavo, we have Marsha -- oh, boy, we're not tired -- we have Toby. Yay. Alan, too.

COMMISSIONER RETCHIN: Well, that was a great report. I do not think I have to begin with "in the interest of transparency," but --

[Laughter.]

CHAIR ROSENBAUM: No. You've been the poster child.

COMMISSIONER RETCHIN: Yeah, I have -- in the subways.

So just one comment -- well, maybe a couple. One

thing you mentioned at the very beginning that I would really emphasize -- and not because it increases the uncompensated costs, but because of the real shift in terms of the burden in terms of safety net hospitals, and that's in outpatient care. So if you look at -- and I'll just take California. I'm not a resident there so I don't have any conflict or anything. But in California, with the 20 acute-care public hospitals, they account for 18 percent of inpatient Medicaid discharges, but they account for 34 percent of all outpatient Medicaid. Thirty-four percent in 20 hospitals.

If you look at what the ACA did, the ACA for many of the community hospitals that had bad debt and many of their uncompensated -- much of their uncompensated care was being admitted through the emergency rooms because of EMTALA. So the ACA in reimbursing them on that uncompensated care now through Medicaid drops to the bottom line, but it doesn't really increase or change the access for the Medicaid population still coming through the ER.

Not true for those that have a portal of entry on the outpatient side where their costs actually have really skyrocketed, more and more Medicaid patients that have

access, that's the only place they can go. So I think whether it's a qualification or a threshold to receive DSH payments, it would certainly help, and where I think the real science or art in this is in targeting. It is amazing to me in some states how much the DSH payments that I call the peanut butter approach smooth across so many hospitals, it's just extraordinary.

CHAIR ROSENBAUM: Gustavo.

COMMISSIONER CRUZ: Yeah. I just had a question that actually goes to what Sheldon just said. Wasn't there a section of the ACA or a provision within the ACA to sort of finally either get rid of DSH or greatly reduce the amount of DSH that they will give to the states, and can you elaborate on that? Because I'm not clear.

MR. NELB: Sure. So the ACA did include reductions to DHS allotments, sort of under this assumption that with increased coverage, there would be decreased uncompensated care. It decreased both Medicaid DSH as well as Medicare DSH, which I can go into if you have questions.

Congress, though, has since delayed the Medicaid DSH cuts. The Medicare cuts are taking effect, but the Medicaid DSH cuts have been delayed to 2018 rather than

2014. That's part of the impetus for this report, is with these cuts coming, how should the remaining funds be better targeted.

CHAIR ROSENBAUM: Marsha.

VICE CHAIR GOLD: Yeah, good report. Nice plan. I think I'll let others comment if they have any tweaks on it, but I thought it was a good plan.

I was interested in sort of helping think through the timeline. If, for example, we were to recommend anything involving a change in DSH, I'm trying to think. If in FY2018, HHS is supposed to do anything, I'm not familiar with what the administrative process is and when HHS would have to start with whatever they have to do. I don't know what they have to do to implement that.

So my main interest is sort of us -- you, actually, just thinking through that, and I don't know if that means it's particularly important if we were to do anything to be very clear on it in December, whether that would make a difference, or if it was impossible because things took so long that we should probably know that, or if it wasn't an issue, we should know that. I just don't know how they implement that change and what timeline they

have or whether they have to publish things or do things.

MR. NELB: I can just comment briefly that CMS on their unified regulatory agenda, they are expecting to have a regulation about the methodology for the DSH allotment reductions in October of this year. So, hopefully, some of our analyses can help inform any comments the Commission may want to make on that regulation.

CHAIR ROSENBAUM: Toby.

COMMISSIONER DOUGLAS: Nice job on the report.

The one tweak or consideration, back to our discussion this morning around supplementals and the changes in the managed care reg, some of the data, I would question the data that you had on supplemental for 2011 would look very different today than managed care, and so states will have less ability to target based on the managed care rule, and how does that impact implications on the DSH side?

CHAIR ROSENBAUM: If I could just follow up on that because I had this down in case nobody else raised it. I knew somebody would. It was trying to bring this morning's discussion and the afternoon's discussion together.

I want to put a question on the table that may be so stupid that I beg forgiveness. I am trying to figure out in my own head what the DSH formula for what can go into the DSH cost factors, would or would not be dealt with in an actuarial value formula; in other words, to the extent that the CMS rule is in part a reflection of wanting to avoid duplicative or actuarially unsound supplementation to a premium payment, it strikes me that there is much going on in DSH that really does not have anything to do with building an actuarially sound premium. So to the extent that you're sweeping DSH in without differentiating its components, I mean, I am wondering. I realize this is so basic, but I am wondering whether part of what we do also, even if it's just a discussion and a side-by-side, is unpacking for Congress what goes into the DSH formula versus what would go into the setting of an actuarially sound rate. They strike me, as in some ways, significantly different.

MR. NELB: That's a good point. We can definitely explore it. The quick answer is DSH can pay for the uninsured as well as Medicaid shortfall, whereas all the other UPL supplements, passthroughs, are -- technically

increases to Medicaid rates for Medicaid patients. But it's a piece we can explore more.

COMMISSIONER DOUGLAS: And isn't it right -- now I'm forgetting. DSH cannot cover Medicaid managed care shortfall, right?

MR. NELB: It can cover managed care shortfall, yes.

CHAIR ROSENBAUM: Let's let the actuary quickly interject and then go back to our regular program.

COMMISSIONER LAMPKIN: Yeah. I would just say for our future discussion, where we really dig in and unpack, a key question is what do we think about Medicaid shortfall, and where is the best place for that to be handled?

CHAIR ROSENBAUM: Exactly. Thank you.

Alan.

COMMISSIONER WEIL: Yeah. This is fun and painful stuff.

I mean, I just think the overlay of state and state flexibility actually comes up more here than in some of the other things we were talking about, and I just feel like it needs to be integrated in because to the extent

that we're talking about what should the criteria be, those are the kinds of questions you ask when you're designing a program. But this is a program that states are making many of the design choices.

We have got the inequities and the levels, the share of the program that's DSH, that state the size of the program in the state. You've got the role of state policy in creating the shortfall because of their own payment rates. You have the role of the state in creating the uncompensated care because of their choices with respect to the Medicaid expansion.

But then you also I think have a very legitimate issue. I mean, I think the peanut butter image is right. So my first job out of graduate school, it was involved in administering the uncompensated care program in the State of Massachusetts, which we ran on a Lotus 123 spreadsheet.

And you are confronted with very important questions. Like, if you have a concentrated number of hospitals that are really doing most of the uncompensated care, you want to fill the gap in for them, but if there is a more distributed problem, you might want to distribute. And the question is, Should the state be the decision-maker

about which of those approaches to take?

So I just think as we're thinking about the policy, it's the parameters, but it's also the interplay. Oh, and sorry, one other thing, which is, of course, the state contribution or theoretical contribution.

CHAIR ROSENBAUM: We have Sharon, Penny, Sheldon, and Kit.

COMMISSIONER CARTE: Rob, I was wondering, would you be able to show the Commission how much of Medicaid shortfall is due to Medicaid births and post-delivery days as well as uncompensated care also?

MR. NELB: We can look into that. So your question is breaking down the Medicaid shortfall by different populations?

COMMISSIONER CARTE: Right. Well, but specific to Medicaid births --

MR. NELB: Yes.

COMMISSIONER CARTE: -- and post-inpatient days related to that birth date.

MR. NELB: Okay. Yeah, we'll take a look.

CHAIR ROSENBAUM: Penny.

COMMISSIONER THOMPSON: I think the conversation

thus far has mostly hit my points.

There's just one thing I don't think has been mentioned is this issue of the underlying reliability and the accuracy and the relevance of the data that we use. Even if we all agreed on the formula, we still have an issue about the integrity of the result because we're not necessarily using data that has accumulated for this purpose and reflective of what we're trying to really measure.

I also think just keeping our eye on the ball of whatever policy we devise or recommend being actually something that we have data or can conceive of a way to have data to rely on in order to implement that policy is an important consideration.

CHAIR ROSENBAUM: Sheldon, Kit, Chuck, Andy.

COMMISSIONER RETCHIN: I wonder if I could just ask you about -- if you could turn to page 7 at the bottom, and I know we went over this. We went through the shock and awe and outrage that Sheldon would be a CEO of a hospital that would make money like this.

So I thought that one of our concerns in terms of the data source was that it included or potentially

included, like, provider tax, and we were unable to separate that out in terms of -- is that right?

MR. NELB: Yes. Yeah, you're right.

So there's more information actually in the appendix, page 26. We have this table that was part of our initial report, and this is based on the DSH audit data. If you add together the Medicaid payments, they're actually, after DSH, are about 107 percent of Medicaid costs for DSH hospitals.

First of all, it's legal because part of DSH, remember, pays for Medicaid as well as the uninsured, so these are 107 percent of Medicaid costs, but are, like, 88 percent of Medicaid and uninsured costs.

But then, second, the DSH audits only give us gross payments, and we know that a lot of DSH hospitals contribute towards the nonfederal share, either through provider taxes or as public hospitals making intergovernmental transfers. The gross payments are above cost, but other people who have been reporting on net payments suggest that the payments are below costs. So there's definitely more to unpack there, and we've been doing some extra analysis that I want to get back to.

COMMISSIONER RETCHIN: So remember the Roger Maris footnote asterisk that Alan brought up earlier? If it's buried in the back, this could be a data problem that deemed DSH hospitals are actually generating a massive profit.

And to that note, if I look at Table C3, it continues to jump out at me, and I know this goes back to our publication. But that deemed DSH hospitals would show a negative 3.4 percent operating margin and then a total margin of 7.1 percent, they either have a balanced sheet of 550 days to generate that kind of investment income or something is wrong with the data.

MR. NELB: Yeah. We actually have been making some more progress in sort of unpacking this, and in the fall, we'll come back to you. We're starting to make sense of the many moving pieces. This chart is with all hospitals, all DSH hospitals, not just the deemed DSH hospitals.

But you're right, Sheldon. We did find in looking at overall margins that those deemed DSH hospitals have negative operating margin.

COMMISSIONER RETCHIN: I was just looking down at

the last row.

MR. NELB: Oh, sorry.

COMMISSIONER RETCHIN: You pointed it out.

MR. NELB: Okay.

COMMISSIONER RETCHIN: Negative 3.4 percent operating margin over a 7 percent total margin, the vast majority of that would have to come from investment income.

MR. NELB: Yeah. There is also a piece. So they have negative operating margins, but then when we looked at total margins, that also includes government revenue. For some public hospitals, we're trying to unpack exactly the difference between the patient margins and the total margins. There's a bunch of things going on, and we'll definitely take a closer look. Yeah.

EXECUTIVE DIRECTOR SCHWARTZ: I just want to interject here, both as sort of a note of encouragement and a note of caution, and that's when we got -- last December, when we finished up the work on the DSH report and we made the recommendation about collecting the data and having that data available for analysis, it was exactly these reasons, because we know that the data have so many problems with it.

At the same time, the Commission said, "Well, if we sit around and say we can't do anything until the data are available, we will be here forever," because that's not something that we control, first of all. Congress controls it, or the Secretary has some authority but has not been acting on it.

So my note of encouragement for you is to sort of remember that notion about what can we do with the data that we have, and the note of caution is when we get to the point where we have done more of the analysis, to be able to sort of put some confidence intervals around them because I don't think we'll ever be in a place where we are totally confident in the data. And you should think about what you're comfortable, given sort of what we think the data in general show.

So don't let the perfect be the enemy of the good, but don't make any wild and crazy assumptions. So that's my sort of mantra to you as we go through a several-month process of looking at different analyses and then you're interpreting them to think about whether you're ready to make some recommendations to Congress about a change in payment policy.

COMMISSIONER THOMPSON: Can I Just build on -- I think that's perfectly reasonable.

I think that the other side of that is, though, not knowing what data cannot be trusted, that it is so unreliable that to look at it is to be misled, to have improper confidence in a certain kind of conclusion, and then the other is that perhaps the data is not present today or not reliable today. But there is a way in which it could be, and executing a new approach that alongside of that has to come a data strategy in order to be able to be able to implement that.

CHAIR ROSENBAUM: I have Kit, Chuck, Andy, Peter for any last quick comments. We do still have a time for public comment, and then we are done for today.

COMMISSIONER GORTON: So mine is just a quick comment. When we get ready to report on this next, I think we need to be careful that we're not fighting the last war. So, in the environment, you have CMS and the states basically trying to figure out how to strong-arm the provider community into transformation using a lot of disparate money, and you can't get out of bed in the morning without turning on public radio and hearing about

value-based purchasing, at least not in Boston.

So I do think that what we will have to do is frame our comments about DSH and other supplemental payments in the context of the new world order of ACOs and value-based purchasing.

CHAIR ROSENBAUM: Chuck.

COMMISSIONER MILLIGAN: [Speaking off microphone.]

CHAIR ROSENBAUM: Are you sure?

COMMISSIONER MILLIGAN: Yeah.

CHAIR ROSENBAUM: Okay. Andy.

COMMISSIONER COHEN: At risk of having tomatoes thrown at me.

In some ways, similar to what Kit was saying, I think sort of DSH is to, like, really big-picture issues about the safety net post-ACA is kind of like CHIP versus -- is to children's coverage post-ACA. We have policy work that needs to be done, recommendations that need to be made, analysis that needs to be due on this little program that is sort of distorted and off kilter to begin with because of, like, its history. But really, the big-picture question is sort of, like, what to do with this thing that

we can't even really define called the safety net that serves so many Medicaid beneficiaries, and the world is changing for the safety net so dramatically. So I just want to say we need to also keep our eye on the big picture and not let the sort of DSH formula discussion get too much in the way of that.

CHAIR ROSENBAUM: I think what you're saying is, Where do special payment rules of various kinds exist in relation to where the program is going? I mean, this is just one slice of the issue.

Okay, Peter. Oh. Well, then we're up to public comments. Public comments?

PUBLIC COMMENT

* MS. GONTSCHAROW: Hi. My name is Zina Gontscharow. I am with America's Essential Hospitals, and we thank the Commission for the opportunity to provide comments today. We have really enjoyed today's discussion, particularly about looking at the big picture. We recognize that that's very important, and we'd like to thank the Commission for continuing to discuss the data limitations. We are fully aware of those as well, and we urge the Commission to clearly note the impact of any data

limitations on any future studies and future recommendations for the DSH program.

Further, we would like to note that we support better targeting of DSH funds to hospitals with high levels of uncompensated care that also provide access to essential community services. This is especially important, as the study calls for an identification of such hospitals, and we continue to urge the Commission to examine the mission-driven hospitals that currently are serving that role. They are the hospitals that are committed to caring for the most vulnerable, training the next generation of health care leaders, providing comprehensive coordinated care, providing specialized life-saving services, and advancing public health in their communities.

We appreciate the opportunity to submit these comments, and we look forward to collaborating with the Commission in the future.

Thank you.

CHAIR ROSENBAUM: Thank you.

Any other public comments?

[No response.]

CHAIR ROSENBAUM: Going once. Going twice.

Well, I think we are adjourned.

* [Whereupon, at 4:59 p.m., the meeting was adjourned.]