MACPAC

Medicaid and CHIP Payment and Access Commission

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PUBLIC MEETING

Polaris Room (Concourse Level)
Ronald Reagan Building and International Trade Center
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Thursday, December 12, 2013
9:32 a.m.

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

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

Session 1: Review of Draft Chapter for March Report: Introduction

Anne Schwartz, Executive Director 3

Session 2: Review of Draft Chapter for March Report: Medicaid and CHIP in the Context of the ACA

Veronica Daher, Senior Analyst 5

Session 3: Review of Draft Chapter for March Report: Strategies to Address Churning

Chris Peterson, Director of Eligibility, Enrollment and Benefits 15

Session 4: Review of Draft Chapter for March Report: Issues in Pregnancy Coverage under Medicaid and Exchange Plans

Amy Bernstein, Senior Advisor 45

Session 5: Review of Draft Chapter for March Report: Medicaid Eligibility Changes: Program Integrity Issues

Moira Forbes, Director of Payment and Program Integrity 75

Session 6: Review of Draft Chapter for March Report: Non-DHS Supplemental Payments

Jim Teisl, Principal Analyst 85

Session 7: Access Measures for March MACStats

Anna Sommers, Director, Access and Quality 106

Session 8: Examining Medicaid Managed Care

Moira Forbes, Director of Payment and Program Integrity 117

Session 9: Review of Draft Chapter for March Report: Selected Issues in Children's Coverage under CHIP and Exchange Plans

Chris Peterson, Director of Eligibility, Enrollment and Benefits 136

Session 10: Review of Draft Chapter for March Report: Long-Term Services and Supports

Molly McGinn-Shapiro, Senior Analyst 167

Angela Lello, Senior Analyst 171

Public Comment Day 1 184

Adjourn Day 1 185

Day 2 186

P R O C E E D I N G S [9:32 a.m.]

CHAIR ROWLAND: Welcome. Let's convene this session of the Medicaid and CHIP Payment and Access Commission, and today we're going to be looking at and reviewing the materials for the March report to the Congress of the Commission.

And we're going to start this morning by asking our Executive Director, Anne Schwartz, to just provide a brief overview of what we're working with as the basic outline for the March report, and then we're going to dive into some of the content.

Session 1:

REVIEW OF DRAFT CHAPTER FOR MARCH REPORT: INTRODUCTION

* EXECUTIVE DIRECTOR SCHWARTZ: Thank you, Diane.

The agenda reflects a draft report that we provided to the commissioners for their review and also sent out for external review to states, to federal officials and to subject matter experts.

The report, as it's being presented to commissioners today, has seven chapters.

The first four chapters are a package of pieces that look at the issues around Medicaid and the ACA, particularly around issues where Medicaid and the Exchanges will interact in ways that are less seamless than I think sort of the notion of people can move from different sources of coverage to another.

The first chapter sets the context for that discussion by describing some of the issues in the ACA and also notes some of the work we'll be doing in the future.

And then the chapters on churning, on pregnancy coverage and program integrity all relate to that package.

We have a chapter on issues in CHIP that looks at sort of the long-term goals around CHIP that the Commission will be coming back to, leading up to our June report and beyond, as well as some short-term issues.

We have a chapter on non-DSH supplemental payments that reflects work that we've been doing over a period of years and then a foundational chapter on Medicaid long-term services and supports.

The report will, as all of our reports, include a section of MACStats. We have a brief session today that talks about some new tables that we'll be adding to the MACStats section. Otherwise, you won't hear much about MACStats at this meeting.

We hope in January to sort of give you some high points of those data. We have to wait a little bit longer for those because we have to wait until some data are available.

There are proposed recommendations in the chapters related to the ACA, related to CHIP and supplemental payments, the chapter on program integrity and on long-term services and supports.

We don't have recommendations proposed in them as they came to the staff although, obviously, by the end of this meeting we'll know where the Commission stands on each of those recommendations.

That's the package that is reflected in the March report and reflects the priorities that the Commission set when it met in a retreat over the summer to look at issues around the edges between Medicaid and the ACA, how Medicaid and CHIP work for the program's enrollees, how payment systems work and how Medicaid serves those who are both high-cost and high-need. That's the rationale behind the package of chapters in this report.

So that sort of sets the context for all the presentations today.

CHAIR ROWLAND: Thank you, Anne.

And now we're going to start with putting Medicaid and CHIP in the context of the ACA. As Anne noted, we're going to have a number of issues that we want to look at with regard to smoothing the transition between existing programs and the implementation of the Affordable Care Act and the Children's Health Insurance Program.

Veronica?

Session 2:

Review of Draft Chapter for March Report:

Medicaid and CHIP in the Context of the ACA

* MS. DAHER: Thank you.

Good morning. Today I am presenting a draft chapter that sets the context for the ACA chapters that follow. The end of this chapter, which I will return to later, talks about issues of interest to MACPAC that we are not ready to touch on just yet but are following.

As you are aware, the ACA implements sweeping changes to the health insurance landscape, including the Medicaid expansion, health insurance exchanges in every state, federal subsidies for exchange coverage for those without affordable insurance, and individual and employer mandates.

The ACA also brings changes to the CHIP program. It extends CHIP funding through October 1, 2015, and increases the CHIP federal match rate by 23 percentage points. It also requires states with separate CHIP programs to cover children 6 through 18 years old between 100 and 138 percent FPL in Medicaid with CHIP funding, which streamlines coverage for the so-called stair-step children.

These changes help maintain a coverage option for kids at every income level where children in both expansion and non-expansion states can move from Medicaid to CHIP to the exchanges. However, some individuals will still remain uninsured.

The Supreme Court ruled in June 2012 that the Medicaid expansion cannot be enforced by withholding federal funds from a state's entire Medicaid program. Twenty-four states then elected not to expand Medicaid.

Seventy percent of the currently uninsured in expansion states will be eligible for Medicaid, CHIP or subsidized QHP coverage versus less than forty percent of the currently uninsured in states not expanding.

Additionally, about 4.8 million people in non-expansion states will fall into a coverage gap because they earn too much to qualify for Medicaid but too little to qualify for exchange subsidies.

There are also those who will not gain coverage due to their immigration status because immigrants not lawfully present are ineligible for Medicaid, and they also cannot purchase QHPs on the exchanges. Immigrants who lawfully present but who have been in the country for less than five years do not qualify for Medicaid but can qualify for premium subsidies if their income is at least 100 percent FPL.

Others will remain uninsured due to the way that premium affordability is determined. Employer-sponsored insurance is considered affordable for all members of the family as long as the employee's contribution to a self-only plan is 9.5 percent or less of family income. This measure of ESI affordability has been called the family glitch or the kid glitch because it does not factor in the cost to insure family members.

Approximately 11.5 million children and adults below 400 percent FPL will likely be unable to afford

coverage offered by their employers but will not have access to exchange subsidies because the offer is considered technically affordable.

This coverage map for adults shows where these gaps may fall. Specifically, in red, those adults in non-expansion states, who earn less than 100 percent FPL but more than the state Medicaid eligibility levels, will not get help paying for insurance.

In addition, some non-expansion states have no coverage options for non-parents at any FPL. These adults would have been part of the new adult group in an expansion state.

This draft chapter addresses several additional issues at the intersection between Medicaid, CHIP and the ACA, including gaps in coverage.

As discussed, people will encounter gaps in the safety net due to states not expanding Medicaid, affordability concerns and immigration status.

Some will encounter discontinuity in coverage due to churning, where relatively small changes in income may lead to individuals changing coverage between Medicaid, CHIP and the exchange. Individuals who churn from Medicaid to the exchanges may need to adjust to paying premiums and co-pays for the first time. Providers may find it difficult to treat patients who move in and out of their networks. And health plans, states and the federal government may find churning to be administratively burdensome as they process enrollments and disenrollments throughout the year.

And there will be complex interactions between eligibility policies on the exchanges. Due to the no wrong door policy, exchanges must build an eligibility system in which Medicaid, CHIP and QHP eligibility policies interact. This requires complex system programming on the part of states and the federal

government. In addition, moving many paper-based processes online has posed challenges to states.

This draft chapter also discusses issues that are still emerging, including characteristics of the new adult group. Some research suggests that they are in better health than current enrollees but that they have pent-up demand for services. There is also a concern that those with greater health needs may be more likely to enroll.

Additionally, increased Medicaid enrollment may affect the ability of providers to serve enrollees.

In addition, disproportionate share hospital payments are reduced under the ACA. These payments are additional compensation to hospitals that serve a high number of Medicaid or low-income patients. Originally implemented because of an anticipated reduction in uncompensated care under the ACA, these reductions will proceed despite the fact that the ACA expansion is no longer being universally implemented. While it remains to be seen how safety net hospitals in expansion states will fare, safety net providers in non-expansion states face an even more challenging future.

Because the ACA provides for a continuum of coverage that extends from Medicaid to QHPs, plan participation in both markets has the potential to smooth transitions associated with churning. A recent analysis shows that 41 percent of QHP issuers also offer Medicaid managed care plans in the same state. Plan networks may vary even if a carrier offers plans on both markets, so more analysis is needed to determine how well multi-market plans can ease the transition for those who churn.

Another concern is that states that had previously extended coverage to adult Medicaid beneficiaries may roll back coverage in 2014 given that these individuals can now obtain health insurance on the exchange. This could especially harm individuals with disabilities with incomes above SSI levels who will not be able to access the full range of Medicaid benefits if they are covered in the new adult group or on the exchange.

Policymakers will also be monitoring the experience of states that enroll the Medicaid expansion population in the exchanges. Arkansas is the first state to receive approval to pursue the so-called private option, using Medicaid funds to purchase coverage on the exchange. This approach has the potential to mitigate churn since enrollees who churn between Medicaid and exchange coverage could keep the same health plan. Iowa and Pennsylvania are also considering pursuing this option.

Still to be seen is how the ACA will affect special populations, including persons with disabilities and medically frail individuals.

During the application process, states must identify those who are medically frail and offer them the choice of the alternative benefit plan or the full Medicaid benefit package. States must also accurately identify with disabilities to ensure that they are determined eligible through disability rules.

Disabled or medically frail individuals who are not determined eligible under the proper pathway may not receive all the benefits they could have received under Medicaid. For example, if individuals with disabilities enter the exchanges, they may not have access to the long-term services and supports that they would have received under Medicaid.

Finally, policymakers will be monitoring the impact of implementation issues on program integrity. The ACA mandates many changes to Medicaid and CHIP eligibility policies. These include moving to the use of MAGI for many applicants and replacing paper-based processes with online adjudication. These changes are intended to streamline enrollment and renewal.

Some of these changes may reduce eligibility errors while others could increase the risk of error. These changes raise questions about whether quality control processes should be revised in light of ACA

policy changes.

These issues set the context for MACPAC's examination of the ACA in this report.

Subsequent chapters focus on anticipated churning among childless adults and parents, and issues of churning and equity in benefits for low-income pregnant women.

An additional chapter examines questions about the program integrity impact of the new eligibility verification strategies.

I'm happy to hear your comments on how to strengthen this chapter. Thank you.

CHAIR ROWLAND: Thank you. Richard.

COMMISSIONER CHAMBERS: Veronica, a great job of putting this chapter together --

MS. DAHER: Thank you.

COMMISSIONER CHAMBERS: -- at least the first draft. It does, I think, an excellent job of putting in context where we are today and what has happened in identifying the very complicated, you know, issues in the future, particularly interaction across the programs.

One suggestion would be, is that, you know, with the publication of the report not until March is really looking at the context of what's happened. So it would be really important that we continue to monitor what's happening with the start of the exchanges, particularly an expansion just, you know, less than a little over two and a half weeks to go. So I'm sure we will, but it would be important to do that. But I thought it was a great job.

All of the issues with provider capacity, market alignment, the future issues that you identified, for someone who runs a health plan which is across all of those lines of business. As we looked at how to

approach this, there's going to be a lot of information that's going to come out as to, you know, how that market alignment works and the churning issue, which we're going to talk about later.

In looking very closely at those, you know, the issues on Medicaid eligibility rollbacks and the concerns we'll have about that, the private option, the special populations, you know, is making sure that people don't fall through the cracks, and I think you've done a great job of identifying those issues very concisely, which I think will inform us into the future work of making sure that we're addressing all those. So good job.

MS. DAHER: Thank you.

CHAIR ROWLAND: Patty and then Burt.

COMMISSIONER GABOW: Good job and obviously this is complex. I think it's worthwhile, maybe, to start out by saying that we already have an incredibly complex system that we are using to provide health care, and that while the ACA certainly was a major step forward and ground-breaking in trying to cover everybody, and I think as a Commission that's interested in access, we applaud that.

But I think it's important to explain that we added yet another layer of complexity on an already extraordinarily complex and uncoordinated system, and that therefore, the consequences that we do have, these glitches that create gaps and non-seamlessness, that we feel as an access Commission have to be dealt with, at least in the short term, until we can get to a more rational system of health care for America, should we live so long. And since I'm old, perhaps not. But I think maybe that framing would be useful.

MS. DAHER: Thank you.

CHAIR ROWLAND: Burt.

COMMISSIONER EDELSTEIN: I'd like to second Patty's comment and suggest that this might be

an opportune place in our report to talk about how the Commission looks both at short-term efforts to integrate and address issues at the margins of programs, but also to talk about how longer term, more reformed strategies might work.

And I apologize, Veronica, if I missed it, but have we addressed in this chapter the difference between the benefit for the expansion population or the benefit for the base population?

MS. DAHER: No. We sort of alluded to it, but we didn't really explain that issue. So we could add that.

COMMISSIONER EDELSTEIN: Yeah, I think that's one where it's helpful for the reader to understand. The example that I'm aware of is the dental coverage for adults. States that provide dental coverage for adults in their base population are appearing to extend that coverage to the expansion population, but they're not required to. And I think it's important to distinguish that.

MS. DAHER: Okay.

CHAIR ROWLAND: Okay. Sara.

COMMISSIONER ROSENBAUM: Yeah, I thought this was a great overview chapter, and one point, though, that I think we might want to try and get in here, which just struck me as not being here, sort of an amalgam of the special populations, the actual alignment problem, is paying close attention to the fact that the new market for health insurance, because it's a market for health insurance built on actuarial principles, is a very structured market with open enrollment periods.

And, of course, Medicaid is not built on actuarial principles. Medicaid is built on other principles, although the managed care component certainly has actuarial principles in it. And one of the important

things about Medicaid, which I think people need to realize, is that if for some reason people cannot make it into the structured market, the very fact there's some overlap in Medicaid allows access at the point of need.

And so, I think one of the things that we're going to have to pay attention to as the Commission in trying to balance all of the issues here is the importance of having a program whose hallmark is being there when people need it, when states need it, when providers need it, up against a program that appears to -- it certainly aligns financially, but in some very fundamental ways is a very different source of assistance.

So if we could capture that somehow? And, of course, CHIP remains sort of, you know, more like Medicaid. You can get into CHIP when you need CHIP. And I think that this is going to become an increasing point of diversion between the various financing streams and one they'll have to pay a lot of attention to.

MS. DAHER: Thank you.

CHAIR ROWLAND: I'd actually like to build on Sara's comment because I think one of the important things this chapter has to do is to explain the difference between the coverage provided through Medicaid and CHIP versus the enrollment through the exchange, and that Medicaid is open from day one. You can get onto the program. There's no open enrollment period.

And the second piece is that many of the changes that the ACA brings about apply to both expansion and non-expansion states. And too often in the things one reads these days, you see it as if the non-expansion states are kind of frozen in time and the expansion states are implementing new things.

But literally, every state is changing their eligibility and enrollment systems. A lot of the other changes going on, especially in the delivery system, are going on across the board. And I think that context is an

important one to go along with the framework.

I would totally agree with Patty that what we're trying to do here is to look at new complexity that's been added and how to really simplify some of that complexity where we can. So our goal in the future chapters will be to really look at how do we make the ACA work better and not be more confusing to the populations that need to be served. Denise.

COMMISSIONER HENNING: And I guess, as someone who actually sees patients and is the hands-on person to provide health care, I'd kind of like to have a little bit more in the chapter as far as, why is it even important that people have access to this health care insurance in the first place? And from my perspective, it's mainly important because they have access to preventative care.

So if you have access to preventative care, including maternity care, but all other sorts of care, if you can catch that high blood pressure before it ends up with stroke in the ER, that saves the system money in the long run. And that's really why it's important to have coverage for as many people as possible, because what you're trying to do is spend your dollars efficiently.

So I'd kind of like to see a little bit more focus in general, not just this chapter, but across everything that we do. As Trish used to say a lot, access to what? You know, the quality behind it, and as Steve said, the idea of, you know, why are you paying extra for this particular program? Is it really going to get you the outcome that you want in the end?

MS. DAHER: Thank you.

CHAIR ROWLAND: Judy.

COMMISSIONER MOORE: One somewhat minor -- nothing's really minor in Medicaid -- a point

that I'd like to see a sentence or two on is the -- and you've got a section on disability population. But we have so much attention in most states on the newly eligible and the referrals they're getting and the new systems they have to set up, but it's focused on the younger population and the non-disabled population.

And in many states, the old leftover many, many, many years and decades old systems for enrolling elderly and disabled people is intact and perhaps suffering because people have to be doing other things. And I think that is something we could cover in the LTSS chapter as well, but I think it's -- I don't want us to lose sight of that because I think it's going to be very critical for those very vulnerable people.

MS. DAHER: Thank you.

CHAIR ROWLAND: Thank you. That's a good start.

MS. DAHER: Thanks.

CHAIR ROWLAND: And to proceed to look at some of these implementation challenges, we're going to ask Chris Peterson to lead our discussion of how to promote greater stability in coverage by looking at how to reduce churning between different insurance plans. And that is at Tab 4.

Session 3:

Review of Draft Chapter for March Report:

Strategies to Address Churning

* MR. PETERSON: Thank you, Diane. In November, we came to you with a list of possible churning issues that could merit policy intervention and asked for your guidance on which ones you wanted us to bring back as potential recommendations, and based on your feedback, we've provided you, as Diane mentioned, in Tab 4 of your Commissioner materials, a draft chapter on churning among parents and childless

adults.

You also have decision memos for possible recommendations, which at our November meeting, you narrowed down to two, on 12-month continuous eligibility and on transitional medical assistance, TMA. We will discuss those two today with some possible alternatives and we look forward to your feedback on whether to move forward on these potential recommendations.

So what I'm going to do is summarize the draft chapter, which is broken up into three parts. It begins with a brief review of churning and its impact, not trying to restate everything that was in the March 2013 report where we had done a more exhaustive description of the issue. And then focusing particularly on churning among parents and childless adults below 138 percent of poverty and strategies to reduce churning among those populations. And then we'll talk about the potential recommendations.

So again, churning is individuals enrolling and disenrolling in different sources of health insurance or to no insurance, often in a relatively short amount of time, for small income changes or other factors. The Commission's focus is on intra-year churning, not churning that takes place at regularly scheduled determinations.

So between those regularly scheduled determinations, enrollees must report income changes, and as a result, they may change coverage. As I mentioned, the 2013 report had reviewed churning's impact, but there's new research that we put in the draft chapter, that the greatest churning in Medicaid is among non-disabled adults under age 65. And that's the population we're talking about here in this chapter.

And just to remind you of some of the numbers that were presented in the November meeting and are included in the draft chapter about how at particular points in time how much -- what share of individuals have

income changes going from below 138 percent of poverty to above.

So as people move from Medicaid to other sources of coverage, by and large we're talking about moving from Medicaid to exchange coverage. Some of those individuals will be subsidized if they're below 400 percent of poverty and don't have an offer of affordable health insurance through their employer. Some will not be subsidized. Then there's employer-sponsored coverage individuals may have access to, and individuals may move to un-insurance.

The vast majority of adults -- as we saw on the prior slide, of those adults in the prior slide who move from below to above 138 percent of poverty, the vast majority would still be below 400 percent of poverty. And then a question that had come up at the November meeting, we've got some additional numbers and this is an example.

Among those adults with income increasing to above 138 percent of poverty at four months, 34 percent would be back under 138 percent of poverty at the 12-month re-determination.

This shows you the income changing among individuals who begin below a particular income level and then go above that level at four months. And so, on the far right-hand side, we saw that already 138 percent of poverty for parents, 20 percent would have an income change from below to above that level at four months.

But as you go to smaller income levels, there is more income changing, so that has implications when we talk about TMA and the role that TMA plays for parents who are covered under 1931 eligibility, which is generally much lower than 138 percent of poverty.

So what does churning cause? Churning causes changes in benefits, cost sharing plans and providers,

and then the chapter goes through some of the strategies to mitigate some of the effects of churning, not all of them necessarily. Veronica mentioned some of these already. So, for example, I'll just go through the first one, plan participation in both Medicaid and exchange markets.

So as an individual goes from Medicaid to an exchange plan, that may address the fact that they won't have to switch plans and providers, but they still may. But certainly their benefits and cost-sharing would change. And then there are these other issues that we talk about.

Again, 1931 is at these lower levels across states and varies widely, and then the new adult group comes in above that for parents. And so, what we'll have is TMA for those individuals in the lower blue bars for those parents, but not in the red ones.

So the first issue for a potential recommendation has to do with continuous eligibility, which allows states the flexibility to waive the requirement that families must report income changes between annual re-determinations. And I want to point out that what that means is 12-month continuous eligibility can provide 1 to 11 months of additional Medicaid coverage.

So, for example, let's say that a person had applied and gotten enrolled beginning July 1st of a year. Then the following year in May, middle of May, they have an income change. They report that. That could affect their enrollment in June. Continuous eligibility says, Don't bother reporting. You can continue being enrolled for that additional month of June and then we'll come to you about your annual re-determination. So in this example, continuous eligibility provided a single month of additional coverage.

Yes?

COMMISSIONER HENNING: So what happens if in July or June, whenever they're getting

re-determined, they decide that they don't qualify for Medicaid anymore, so then they need to buy exchange coverage, but open enrollment is not until January?

MR. PETERSON: But losing Medicaid counts as an exception, so you can enroll in exchange coverage at that point.

Currently, 12-month continuous eligibility for adults in Medicaid is not a state plan option. It is permitted under a Section 1115 waiver, but there are issues around the Federal matching rate. This was discussed in your draft chapter, but there's still some confusion about this.

When you think about, for example, continuous eligibility under CHIP, states get the entire enhanced Federal match for CHIP throughout that 12-month period. There are no questions about that. There are questions about this for-adults in the new -- who are newly eligible and entitled to the 100 percent match.

Arkansas said, in their draft waiver application when they were doing the private option, they wanted to do 12-month continuous eligibility for adults. CMS came back and said, You will not get the entire newly-eligible, 100 percent match for those adults. You're going to have to come up with some -- and what that some is we are still trying to get clarification from CMS.

But the point is, is that there's some confusion around the matching rate on using a waiver approach to do 12-month continuous eligibility for adults.

COMMISSIONER ROSENBAUM: So just to be clear, you're saying that when CMS put out the option in May of 2013 -- I think it was May, I've lost track now -- to use 1115 to do the 12-month, the discussion of how Federal contributions would be calculated for states using that option was not laid out?

MR. PETERSON: Not in great specificity, so that states were aware of this as a potential issue.

COMMISSIONER ROSENBAUM: Okay.

CHAIR ROWLAND: And 1115 waivers have generally not allowed for changes in the matching rate itself. That has been -- you can make other groups eligible for Federal funds, but changing the matching rate has not been something directly you can do with an 1115 rate.

MR. PETERSON: In our March report from 2013, we recommended that Congress authorize 12-month continuous eligibility statutorily for adults. We also, as part of that recommendation, put children to have 12-month continuous eligibility as an option under CHIP, but we will be talking about that separately as part of the CHIP chapter.

So the potential recommendation here is focused on 12-month continuous eligibility for adults in Medicaid. It says parallel to the current state option for children in Medicaid, the Congress should create a statutory option for 12-month continuous eligibility for adults in Medicaid, enabling states to continue receiving their matching rate for those populations. That last clause trying to address the confusion around what came up with Arkansas under the waiver approach.

So what this would do is add a state option for enrollees to continue to access to Medicaid until the next regularly-scheduled re-determination if states chose to take up this option. Research shows that 12-month continuous eligibility reduces churning. 12-month continuous eligibility makes Medicaid enrollment more consistent with exchange and employer-based coverage in terms of being annual. And the rest of my slide is cut off.

So anyway, the cost, which does not appear on the screen but I think is in your packet -- is it not? Okay.

CHAIR ROWLAND: It is. It's really on your slide. It's just that, I guess, it's too shocking to reveal.

MR. PETERSON: It's in invisible ink. Thank you.

VICE CHAIR SUNDWALL: You should have had this memorized.

MR. PETERSON: Yeah. My brain is full. And one of the comments that came up in the chapter, and this is worth addressing again, that --

CHAIR ROWLAND: Chris, you can actually say out loud what the cost is.

MR. PETERSON: Oh, I will. I just wanted to address the second-to-last bullet, which is half cut off, regarding 12-month continuous eligibility leads to less administrative burden, but longer average months enrolled. And also, which was mentioned in the chapter, longer months of enrollment leads to lower per capita average monthly spending.

Now, if you multiple that by the number of months that people are enrolled, then it's higher. So there's two things going on with that. So the point being --

COMMISSIONER EDELSTEIN: Chris, do we know --

MR. PETERSON: -- that the longer that people are enrolled, they get preventive care that avoids some unnecessary hospitalizations, for example.

COMMISSIONER EDELSTEIN: Do we know what the administrative cost is to re-assess people's eligibility intra-year?

MR. PETERSON: We've heard different estimates on the dollar amounts, and some of the state-level folks can jump in on this. But it's been estimated of like -- I've heard ranges from $50 per

re-determination to $200, but those were some conversations a while back. So I don't know how that's changed, you know. With the new electronic systems, are these going to be better and much less expensive?

COMMISSIONER EDELSTEIN: So with the administrative costs and the health savings costs, do we know what the net financial cost is to the state?

MR. PETERSON: The estimates have varied. We've talked to a number of states. Some states have estimated that it would produce savings, and in that state, when they recommended doing 12-month continuous eligibility for children, they said, We think this is going to save money and, you know, the other legislative affairs folks said, Are you really sure about that? Because you're going to have longer months of enrollment. Is that really going to happen? Yeah, we think so.

They thought so and so far they have not seen an increase as a result. So I think where you see the higher estimates of the impact on states is among states that have not implemented it and are estimating much larger impacts. So, for example, we heard from one state who said, Right now our average months of enrollment for children is nine-and-a-half months. If we do this, it will go to 12 months, which would increase our costs dramatically.

But, in fact, that's not correct because in the example that I gave where the person had one additional month of coverage, if their income was still above whatever the eligibility level is in that state, they would go off at the end of that 12-month period.

So in that example, that person would have had only six months of Medicaid coverage, six months not. So considering, you know, people coming in and out through their regular re-determination, it is not going to create 12 months of coverage for everybody. So I think that --

CHAIR ROWLAND: You know, isn't one of the other differences, rather, the state is paying claims on a fee-for-service basis versus capitating to managed care plans? Because if you're paying on a fee-for-service basis and people are covered for 12 months but don't -- a lot of people we know don't use services, so that you don't incur the same kind of cost for the continuous eligibility as you do when you're contracting on a per capita monthly basis with managed care plans.

CHAIR ROWLAND: Which is the direction, obviously, that most of the states are going. David had a comment.

VICE CHAIR SUNDWALL: Just quickly. You'll recall when we did this recommendation last year, Utah said it would cost them $20 million. I'm not sure how they came up with that, but it was not a welcome recommendation based on what they anticipated would be increased costs to the state. So I don't know if you've done a more formal survey, but there's not uniform support for this.

MR. PETERSON: And I think their assumption was the 12-month part.

COMMISSIONER GABOW: Sometimes when we don't have actual data like, in this case, what's the real cost and what's the savings on better health, a surrogate can be what doesn't happen. So do we know how many states that had continuous eligibility decided to drop it because of cost? And if that number is zero, given how sensitive states are to costs, that would be, I think, a surrogate indirect measurement that it probably saves money. Otherwise, states would probably not continue something. So do we know that one little fact that might be quite useful?

MR. PETERSON: I have no memory of any state dropping it, but we can double-check that with the folks who do that analysis.

COMMISSIONER ROSENBAUM: But I would say that shortening periods of enrollment to Medicaid is a long and time-honored approach to saving money. So it is very much the case, whether it's true or not, but the perception is that if you had, say, a six-month re-determination period and you're tight on money, you drop to a one-month, two-month, three-month period of re-determination.

So it's not -- it would not be unusual for a state to think that shortening a period of enrollment would save the state money.

CHAIR ROWLAND: But one of the other things that we've seen with the children's experience is that lengthening the time for re-determination, even if you don't do continuous eligibility, but stretching it out helps you to not drop so many kids off at the other end. So we have an issue here of how to keep people on the program.

And certainly, all of this is because of the means tested nature of the program, that a change in income generates, whether you stay on the program or not, an income going down is not a problem. It's income going up that causes people to change. But this is an issue they're going to deal with in the exchange, in the marketplaces as well, because the subsidies will be based on an income and changes in income will, in fact, cause people to have to repay some of their subsidy at the end if they don't.

So we're dealing now with whenever you have benefits related to different levels of income and those levels change, how do you smooth that curve.

MR. PETERSON: And I also want to remind Commissioners that this is to give states an option to do something. So if Utah says, We don't want to do that, then this option says you don't have to do that. But for states who want to do it, to have that option available, that's what this recommendation is about.

CHAIR ROWLAND: And it's because the previous way in which income was calculated with disregards allowed states to do this, that the new MAGI rules have imposed a barrier that was not there previously.

MR. PETERSON: And I also just want to say out loud that the CBO has estimated the cost of this at $50 to $250 million in 2015 and less than a billion dollars over five years. So obviously, it's the smallest five-year bucket that they have available besides zero for estimating the Federal cost.

CHAIR ROWLAND: Okay. I have Donna, Andy, Trish.

COMMISSIONER CHECKETT: Chris, just out of curiosity, when you were talking about how people report a change in income and this causes the churning problem, what do we know about the percentage of people who probably have a change in income, do you report it, and how do they do that? Are they doing that? They call up their caseworker, they send a letter? Tell me a little bit more because I understand churning is a real issue, but I don't always know how real it is.

MR. PETERSON: And I think that's a great question. We've talked to state folks and you hear variation in terms of the extent to which they think people actually report those changes. But the Federal application for HealthCare.gov, the paper application says, right above your signature line, if you have a change in income you need to report it and you call us at this number or you report it online.

Most states have a similar thing where it says you must do this. It doesn't say that there are penalties associated with that. There are penalties in the prior bullet which says, If you misrepresent things on here, you could be subject to penalty. And states have change forms so that in the same area of the Website for most states where you can go online and get an application, you can also go on and get a change form to say,

This is how my income has changed.

COMMISSIONER CHECKETT: Thank you.

CHAIR ROWLAND: Andy and then Trish.

COMMISSIONER COHEN: Chris, do we know -- I don't know how much we know about the CBO estimate, but I have a hunch that I just wanted to explore with you. I'm hunching that they are assuming that very, very few states will take it up and that's why it's quite inexpensive. And I'm wondering, tell me if I'm wrong, tell me if I'm right, and tell me if we don't know. If that's the case, I just think we should be very clear with ourselves about that, about the limited impact.

You know, we have made a strong case about churning. I don't think we know everything we'd like to know for sure, but I am -- I want us to be aware if this is a very limited impact. This is really just returning some flexibility that states had in a different way previously, or is this really sort of moving the ball towards a less-churny Medicaid?

MR. PETERSON: CBO does try to take into account state take-up, so if state take-up is low, then you're right, that's going to cost less. I think they probably are thinking that there's going to be not a lot of take-up, but then again, with 100 percent matching, you know, on some of those populations, that --

COMMISSIONER COHEN: It's some, though, right?

MR. PETERSON: Yeah, sure.

COMMISSIONER COHEN: I mean, it's not -- I mean, you can't have a policy that says only 12-year [sic] continuous on your newly eligible or something like that.

MR. PETERSON: No. The other reason for relatively low costs is that to the extent you assume

that individuals go to some other form of Federally-subsidized coverage, whether it's TMA or, you know, exchange coverage and 12-month continuous eligibility keeps individuals on Federally-subsidized coverage, then there's little net cost to the Federal Government. So that's another consideration.

CHAIR ROWLAND: Chris, can you explain how this recommendation differs from the recommendation that we previously made?

MR. PETERSON: Substantively it does not except that we are breaking out CHIP children from adults in Medicaid. The only substantive addition was that last piece that tries to clarify the matching rate issue. So really this is no different.

CHAIR ROWLAND: In essence, just the same recommendation we've previously --

MR. PETERSON: Correct.

CHAIR ROWLAND: -- forwarded. Trish.

COMMISSIONER RILEY: I guess I'm concerned about costs to states and I've appreciated the discussion about the savings when you lock people in longer, but I remain -- because I live in a fee-for-service state, I remain somewhat skeptical. And particularly as I think about Table 6, which I think is really a very useful one, that will both -- this churn is both newly-eligible and the legacy population. So there's different match rates for this.

So the implications that states still raise some red flags for me -- and I guess I'd like you to follow up a little bit more about the point you just made. As a matter of equity, if you lock people into a Medicaid program who are otherwise eligible for subsidies, I'd rather have the exchange pay for that cost, if there are costs, but having netted out, I mean, what you just alluded to, in the CBO's estimates, do they net out the

savings to the exchange for people who would have churned into a subsidized product?

MR. PETERSON: Yes.

COMMISSIONER COHEN: They do net it. Okay. Thanks.

MR. PETERSON: And again, the point of 12-month continuous eligibility is to create those 12-month annual enrollment periods so that they'll go to the exchange coverage once that 12-month period is done if their income has gone up.

CHAIR ROWLAND: Andy and then Patty. Patty.

COMMISSIONER GABOW: I just wanted you to clarify something you said, Diane. You said that -- I thought you said that this just enables states to have the same flexibility they had previously before MAGI. If that is true, that's a very big point. To say we're just restoring something that they had before, then that should be called out and highlighted. But I wasn't clear about that. Could you elaborate?

CHAIR ROWLAND: Well, it was the way in which they were allowed in the past to do re-determinations. They could do them annually and they could also do various things in terms of deduction and set-asides that are not now allowed because MAGI has a uniform 5 percent set-aside.

MR. PETERSON: So prior to MAGI, states had the flexibility to disregard all kinds of income as they so chose. In this example for 12-month continuous eligibility for adults, they could have said, We, state, choose to disregard all income that changes between re-determinations, and that would have effectively accomplished it.

The only counterpoint to consider is that no state took that option up. In other words, they had the flexibility, but they didn't do that. So that's why we mentioned it, I think, in our March 2013 report, but did

not make a big deal of it considering --

COMMISSIONER GABOW: But I think if that is restoring -- whether they took it up or not is almost irrelevant because we're not mandating this here. We're saying --

COMMISSIONER ROSENBAUM: A policy option.

COMMISSIONER GABOW: -- a policy option. So I think it's important to underscore they actually had this policy option before the use of the MAGI restricts that policy option to a degree, and we want to see it be as flexible as possible. I think that's a key point to say. We're not plowing a new road. We're just reopening one that got rain damage or something. I don't know.

CHAIR ROWLAND: Chris, what are the time periods for re-determinations now under the new MAGI system by state?

MR. PETERSON: Well, it's 12 months, is required now. Is that what you mean? Between the --

CHAIR ROWLAND: Yes.

MR. PETERSON: -- regular re-determination? So the law previously had said no more than 12 months. Let me think about the language. Anyway, states could do re-determinations. There were a couple states that for children, for example, were still doing re-determinations every six months. Texas is one. I forget the other one. Under MAGI, they can no longer do that. For MAGI populations, you can only do re-determinations at the 12-month period.

CHAIR ROWLAND: So doesn't that somewhat, in effect, give people continuous eligibility?

COMMISSIONER ROSENBAUM: No.

MR. PETERSON: No.

COMMISSIONER ROSENBAUM: That does not deal with the fluctuation.

CHAIR ROWLAND: The fluctuation, I think. In terms of when they report it.

COMMISSIONER ROSENBAUM: Right. But your point before was correct --

CHAIR ROWLAND: Right.

COMMISSIONER ROSENBAUM: -- as Chris explained it, which is that you could use a 12-month period and as a matter of law, you could, if you were a state --

CHAIR ROWLAND: Waive the income --

COMMISSIONER ROSENBAUM: -- say that any, you know, amounts above a nominal amount, whatever it is, you don't need to report at all. States didn't do it, but they had the legal option to do it. Now that we're on a MAGI system, what hasn't happened is that we haven't reframed the old option in the new language. And so, really one can argue that all we're doing here is restoring flexibility that had been in the law previously.

CHAIR ROWLAND: To Patty's point.

COMMISSIONER ROSENBAUM: Yeah, exactly. Okay. Robin and then Norma and then Andy.

COMMISSIONER SMITH: When I think of churning in my mind, I'm thinking not of a one-time move. I'm thinking of people who either have seasonal jobs or, you know, occasionally will get a job that bumps their income up a little bit and then they're back.

So when I think of churning, I'm just not picturing bumping up one time. I'm thinking of the people that are constantly moving back and forth, for whatever reason, and there's a lot, especially in the lower income group. So is that not a valid point, that we're not talking about a one-time administrative cost?

We're talking about, you know, just back and forth and back and forth.

COMMISSIONER MARTINEZ ROGERS: Which mine goes along with what Robin was saying. My statement is that in Texas, because there are so many seasonal jobs, in particular, with the migrants, even though some of them might get different health care, the issue is that every six months in Texas, really it is -- it's really -- I mean, the administrative cost, but not only that, no wonder if we have so many uninsured children, because they're going back and forth because of the seasonal jobs. That's really not good.

MR. PETERSON: And to that point, that was one of the reasons -- and this had come up in the last meeting about people coming back, their income dropping back. That's why we had put in that example of those numbers, that among those whose income goes up after four months, 34 percent are back down. So we've added that, but we can flesh that out a little more to make that clearer.

COMMISSIONER COHEN: I wanted to follow up on Trish's point and see if we could make it a little bit more -- turn it into an action. I am worried about a potential cost being imposed on states. It could be one that they're picking voluntarily. And it's one that seems a bit unfair because they are, as you said, CBO did tell you there are offsetting savings potentially from the exchanges.

So I'm wondering, while we can't, I don't think, specifically make recommendations about the exchange, I wonder if in sort of prefatory language or in another place we might say, policy-makers should also consider whether there could be a mechanism to appropriately allocate, you know, the savings that would come to exchanges of states picking up this option, in some mechanism and sharing that back with states.

For us to design in, I think, actually, potentially we could make some recommendation around that. But, you know, dollars are dollars and there are ways that we could think about and there are many ways that

the Federal Government has done this before.

You know, some are more popular than others, claw backs or this or that or the other, or, you know, some sort of a reverse audit where you, you know, take 200 cases, you look at them more carefully, you figure out which proportion of them really had this change. You assume some percentage of them would have gone through change.

Whatever it is, I feel like for me that's an important piece for us to put in there, that there should be some consideration of a way to allocate savings from the exchanges back to states that pick up this option.

CHAIR ROWLAND: I think we need to be careful, though, that this doesn't just apply to the newly eligible who might be going into the exchange. If a state decided to do continuous eligibility it could apply to the legacy Medicaid populations so that --

COMMISSIONER COHEN: Right, exactly.

CHAIR ROWLAND: So that's an important point to raise, too. This is not just an issue about the newly-eligible. It applies to people in other states. It applies, certainly, to people in a non-expanding state whose income goes above 20 percent of poverty and they're still in the gap and they're not eligible for coverage in the exchange. So that, in effect, that would be one way that some of the states that are not expanding could, in fact, provide some greater protection to people who otherwise will end up uninsured, and maybe that's worth noting in the chapter as well. But David had a question.

VICE CHAIR SUNDWALL: My question relates to this. I want to be clear that churning is not a new issue created by the ACA, that this is something that's been a problem for some time. So if it's not just ACA-related, do we now have an estimate of the scope of this problem or the magnitude of it? Are there any

figures that you can give on numbers of people who churn or have churned? Or do we expect more under the ACA?

MR. PETERSON: So I think those are the figures that showed the percentage of people who have income changes at four months.

VICE CHAIR SUNDWALL: I mean, that shows that they could, but are they? I mean, in fact, are they changing? I mean, I can see that they would potentially be able to do so, but is that, in fact, happening?

MR. PETERSON: So the challenge with that is -- reasonable question. The challenge with that is we have this new expansion that's coming online in 2014 and some folks are trying to estimate not only how many people are going to have an income change, but what they will be eligible for and whether they will enroll in whatever that new coverage is or be uninsured.

We have not as of yet opted to use those kinds of analyses because they build on a lot more assumptions about what people will do and take up. And so, we've opted just to show the level of potential churning from the income changes and we'll wait to see how that really plays out in the real world.

VICE CHAIR SUNDWALL: Thank you.

CHAIR ROWLAND: Okay.

MR. PETERSON: Shall we move on to the TMA issue now?

So current TMA, Section 1925 TMA, for the wonks, requires states to provide six months of TMA and then to require states to provide 12 months if individuals continue to meet certain criteria, and these are for parents and children who were eligible under 1931, back on that prior slide where I showed the blue bars. So relatively low levels of income as a percentage of poverty.

GAO did a study and got answers from 43 states who reported enrollment of over 3.7 million individuals. And the 36 states who reported expenditures reported $4.1 billion in TMA expenditures. At this point, current TMA is scheduled to end after December 31st, 2013. Congress has done annual or, you know, other short-term appropriations for some time now.

It's important to note that if Congress does not extend current TMA, it reverts back to what was in place, and is permanently funded, based on the old 1980s policy, which is four months in duration rather than six to 12.

COMMISSIONER ROSENBAUM: Can I ask a clarifying question? So what you're saying is that as part of Medicaid's permanent statute, the four months are the standard.

MR. PETERSON: Yes.

COMMISSIONER ROSENBAUM: That Congress then, essentially, on an annual basis, has extended transitional medical assistance to 12 months? So what we have is a permanent authority of four months, but a year-to-year extension to 12 months?

MR. PETERSON: Yes. And just as background, I think when it was first done, it wasn't an annual basis. It was several years, but since then it has turned into a year-to-year kind of thing. There are some differences around the margins in terms of the policies with respect to the 1980s one, so if current TMA did end and states had to revert back, they would have to make substantial -- I talked to one state and they said it would be substantial changes to their eligibility system to account for what seems like relatively minor differences.

CHAIR ROWLAND: But the authority to do transitional medical assistance is in the statute. It's

not enacted on a year-to-year basis. What is enacted on a year-to-year basis is the ability to broaden that from the four months to the 12 months and the funding for doing that.

MR. PETERSON: And really just the latter part. It's just the funding. The other aspects of current TMA is in the statute in Section 1925. It's just the funding part that has to be extended.

COMMISSIONER ROSENBAUM: But just one other point of clarification. The authority to go to 12 months is only for a sub-slice of parents and children? It's only for, as you call them, 1931 parents and children? Who would not be a 1931 parent and child?

MR. PETERSON: Well, the poverty-related children. So that would be, you know, we think of children as being eligible for Medicaid up to 133 percent of poverty. But those who are above those 1931 levels would not be eligible for TMA.

With respect to parents prior to the ACA, really 1931 was the only pathway available. That slide showed, however, that now there are other states. There are states who are doing the new adult group, so parents above 1931 can enroll in the new adult group, but TMA is not available to those parents.

COMMISSIONER ROSENBAUM: So it's really an issue in states that have not enacted the expansion? That's the biggest area where this really matters, I assume?

MR. PETERSON: Yes, in terms of preventing uninsurance?

COMMISSIONER ROSENBAUM: Yes.

MR. PETERSON: Yes.

COMMISSIONER ROSENBAUM: Yes.

MR. PETERSON: So to the next slide about the proposed recommendation, which is identical to

what we had put into the March 2013 report. It's two pieces. Congress should permanently fund current TMA while allowing states to opt out of TMA if they expand to the new adult group added under the ACA. So permanently funding TMA will prevent uninsurance of parents whose income increases, particularly in the non-expansion states.

Permanently funding TMA will end states' uncertainty about what is going to happen with it. It will allow -- the second part would allow expansion states to opt out and permit them to eliminate some unnecessary confusion and administrative burden for enrollees in state Medicaid programs and exchanges.

COMMISSIONER ROSENBAUM: So again, what you're really -- what we're really focused on now is to use 12 months as the permanent standard for transitional medical assistance as opposed to staying with the four months?

MR. PETERSON: Yes.

CHAIR ROWLAND: And if a state adopted 12-month continuous eligibility, how would that interact with this proposal?

MR. PETERSON: The next slide. So we have cost estimates from CBO. The current proposed recommendation is that the two-piece thing that I've outlined would cost, in a single year, $750 million to $2 billion. I should note that CBO has these kind of ranges that they give us their estimates in. So that's why these numbers are what they are in terms of the ranges. And then over five years, it's $5 to $10 billion.

That number is a lot larger. If you remember what we had in our March 2013 report, which showed for one year much smaller spending, and actually savings over the five-year period. So what has happened is CBO has redone their estimates and they had neglected to take into account the cost of that second part of the

recommendation.

So current law is that four-month TMA continues forever. The second part of our recommendation says, If states do the expansion, they can opt out of TMA, and if they do that, then individuals who would have been in this regular match four-month TMA, many of them will go to newly-eligible, 100 percent match. That's where the additional cost is. And that is shown by the next part there.

CHAIR ROWLAND: It's a savings to the states.

MR. PETERSON: Correct, exactly. So the second part is an alternative to only permanently fund TMA. So just in the first part of the recommendation with no opt out, there you see relatively small first-year spending, but then savings over the five-year period.

So what are some options to address kind of the additional costs in the second part of our current recommendation? Well, what if you, in the same way that you permit states to opt out, those expansion states, what if you said you can only opt out if you replaced TMA with 12-month continuous eligibility?

In that sense, it keeps those individuals in regular matched Medicaid. And so, that reduces the Federal cost, but then, of course, increases the state spending as a result.

So states would probably like what we have to say in this option and CBO actually assumes that all the states, the expansion states, would do this. They would take up that option. So there's that.

And I just want to update you, also, as I said, the opt out part of the main proposed recommendation was the coster from the Federal perspective, but that also means less spending from the state perspective for states that take up that option.

In that context, with funding for current TMA ending after December 31st, later this month, the

House and Senate just released this week their own draft language to address TMA. It is part of a larger package that Congress is dealing with, Medicare, SGR, and other issues.

Regarding TMA, the Senate Finance Committee Chairman's draft proposal, what they call the Chairman's Mark, has a two-part approach similar to ours to extend TMA. First, rather than doing a one-year or shorter term extension, the Chairman's Mark calls for a five-year extension of TMA, not permanent.

The second part would allow expansion states to opt out of TMA, but they would have to continue with the 1980s version of four-month TMA. So while this approach permits an opt out in a way that prevents CBO's protected increase in Federal spending, not many states are likely to take up that option, except that there is another carrot, if you will, in the Chairman's Mark, and that is, if an expansion state opts out of current TMA, the state would also be exempt from the ACA's maintenance effort for children that is currently in effect through September 30th, 2019. So that's what the Senate Finance Committee Chairman's Mark says.

COMMISSIONER ROSENBAUM: I'm sorry. Can you take us through that one more time?

MR. PETERSON: Yeah. The first piece is five-year extension of current TMA.

COMMISSIONER ROSENBAUM: Right.

MR. PETERSON: The second piece is an opt out for expansion states. They can opt out of current TMA, which is six to 12 months. But they would be opting out to four-month TMA, the 1980s version which would require them to make the eligibility changes to their systems, et cetera. So one might think that they may not be likely to pick that up.

But, if they take up this opt-out they would also be exempt from the maintenance of effort for children.

COMMISSIONER ROSENBAUM: Got it.

So they'd have to -- essentially, they'd have to do four -- it's sort of like you have to do four months --

MR. PETERSON: Yes.

COMMISSIONER ROSENBAUM: -- of the old TMA system.

And then we'll let you -- basically, you'll roll those people over into 100 percent financed for the time being, federal coverage as to the expansion group, and you can get out from under the maintenance of effort for children.

MR. PETERSON: You're saying that once the four-month TMA ends then they could go to the new adult group.

COMMISSIONER ROSENBAUM: Right. Exactly. So, essentially, they're financing some portion of the time.

They don't get to opt out free of charge, basically. They're going to have to do four months.

MR. PETERSON: Right. And CBO's baseline assumes that there is a four-month TMA.

COMMISSIONER ROSENBAUM: Right.

MR. PETERSON: And after four months --

COMMISSIONER ROSENBAUM: Right.

MR. PETERSON: -- they turn newly eligible.

So there's no --

COMMISSIONER ROSENBAUM: Essentially, turn the clock back 30 years or whenever -- 25 years, whenever the original TMA came into being. Go back to that, reset, you do your four months, and

then you go into the expansion group.

MR. PETERSON: Yes.

CHAIR ROWLAND: And why the repeal of the MOE for kids?

MR. PETERSON: I don't know.

CHAIR ROWLAND: What their justification is.

MR. PETERSON: Let me also note that yesterday House leadership unveiled their package that also addresses TMA. It is a simple three-month extender bill. So it would extend TMA through March 31, 2014.

So that is some of the breaking news on TMA, and we look forward to your discussion on the TMA recommendations.

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: Thank you. This is, I was going to say, enlightening, but that's not quite right. It's informative, very informative.

Why couldn't we -- if it's the consensus of the Commission that this be adopted -- just say fund?

Why do we have to say permanently fund, as Diane pointed out? That's stark language, I think, for any commission, to say we should do something in perpetuity.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: To that question, maybe we can say funded as part of the Medicaid law. As you pointed out, Medicaid itself is not necessarily permanent. You could play with that language.

But my question was, if we made this recommendation already in March -- now I believe in perseveration. I actually do believe in that because, well, it's a psychiatric diagnosis.

[Laughter.]

COMMISSIONER GABOW: I have found that perseverating on points, eventually, somebody hears you.

So is this that philosophy of perseveration, or is there some unique reason to make it again?

CHAIR ROWLAND: Why are we repeating our recommendation, is her question.

[Laughter.]

MR. PETERSON: I guess I would just note it is up to you.

I mean, I think you could say the Senate Finance Committee Chairman's mark reflects some acknowledgment of the approach that we recommended in March.

So, if the purpose is to affect policy, then I think you could say this has gotten the attention of folks; it is reflected in draft legislation. And that could be enough.

COMMISSIONER GABOW: And not in all draft legislation.

MR. PETERSON: Correct.

EXECUTIVE DIRECTOR SCHWARTZ: I think there's another point here, too, which is sometime between now and the end of the year, which is before our report comes out, there is going to be some action, which we cannot tell you what it is now. We don't know whether it's going to be what the House is putting forward or what the Senate is putting forward or something completely different.

The issue on the perseverating is, do you still believe that it's important for something to be done about it, whether it's, you know, what's come up here now or some tweak on that in light of new information, or is it also -- you know.

It's within the role of the Commission to say, we could understand why certain political decisions are being made at the federal level just as we understand at the state level, but in thinking about how the policy would work best, this would be our best recommendation.

So that's something I think you guys need to think about as you figure out what's the right thing to say here, whether it's important to say it again or whether it's important to say something, again, that's slightly different or whether you feel like events have marched on.

CHAIR ROWLAND: Or, rather, we just reemphasize the recommendation we made before.

Patty and then Judy.

COMMISSIONER GABOW: Well, not to be light-hearted about it, I do think that if we made a recommendation and we believe it and it hasn't yet gone into law, restating by saying we made this before, but we still think it's important, so we're placing it back again on the table, I think is fine. And I don't object to that, but I just wanted to make sure there was no other nuance that I was missing.

MR. PETERSON: And the only other nuance that I guess I would recognize is the fact that the CBO score has changed so much. And when we did this recommendation in March, we said there's very little cost and, in fact, some savings. But now, you know, the situation has changed. And so does that then merit additional consideration? Do you drop that second part?

Do you say, well, now it's not worth doing the opt-out?

Or, do you say, you know what; that opt-out should be paired with 12-month continuous eligibility so that people don't churn straight off of 1931 coverage to nothing, as could be the case?

CHAIR ROWLAND: So the question is whether we want to modify our recommendation.

MR. PETERSON: Correct.

CHAIR ROWLAND: Judy.

COMMISSIONER MOORE: I think this discussion has gotten beyond what I was going to say.

I was just going to say in the context of the whole, the chapters and the report itself, the whole first section of the report, you know, we're worried about Medicaid's interacting with the other provisions of the ACA and the exchange and churning and what it will mean. And I think we shouldn't ignore this because this is a big part of that problem.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: Yes, I actually think I'm quite concerned about simply repeating our same option when we now know that the cost is significantly different because of the oversight in the original cost calculations.

Putting aside the maintenance of effort for children, I think the issue of making -- I mean, I think coming back to this every year, which is what we're doing, is foolish.

I think that, again, setting --

MR. PETERSON: You mean Congress coming back to it?

COMMISSIONER ROSENBAUM: Yes, yes, not us. I mean we keep running after it because it comes back every year.

But the fact that this issue continues to languish in Congress on an annual basis is silly. It deprives states of the certainty they need right now. Because transitional medical assistance is a legacy eligibility category, states are staring down the barrel of 12 months of lost funding for the expansion group.

And so I think, actually, rather than shortening -- you know, you could -- in the face of the CBO estimates, we could say, well, do it for two years; make the fix for two years or whatever.

I think it much more sense, quite frankly, to roll back to the four-month extension since that does bring the cost down a little bit, and then states would roll over directly after that. The group would become a newly eligible group, if I understand the policy.

And so states would not get quite the full relief of immediately being able to access the expansion, but it would be at least some mitigating factor on what has turned into this very high unanticipated cost because I think that the greater downside is if the House and Senate feel that this is too expensive and just leave another year in place, or whatever, and we come back to this issue again next year.

So I think given everything that has transpired I would prefer to see MACPAC adjusting or modifying its recommendation to reflect the new budget estimates.

It does seem to me that the Senate Finance Committee's approach, again, putting aside the maintenance of effort question, is a reasonable one.

CHAIR ROWLAND: I, however, would be very uncomfortable with a recommendation that doesn't look at the impact of the policy on the expansion versus the non-expansion states because I think that this provision is going to be critically important in the non-expansion states and we don't want to be making a recommendation that will really limit the coverage options for some of the poorest people in those states.

COMMISSIONER ROSENBAUM: Yes. I mean, just to clarify, my big concern was what to do about mitigating the effects in the expansion states. To the extent that the non-expansion states would also get the benefit of dropping down to 4 months, essentially wiping out the 12-month extension does not seem to

be progress.

CHAIR ROWLAND: Okay. All right. Well, I think we've given Chris a fair amount to think about.

And now we'll move on to talk about another provision that has some implications, which is the pregnancy-related care. So, Amy Bernstein will join us, and we will move on to tab 5 in your notebooks.

Session 4:

Review of Draft Chapter for March Report: Issues in Pregnancy Coverage under Medicaid and Exchange Plans

* MS. BERNSTEIN: Thank you.

Move on to another issue of interest to all of you that you heard about at the November meeting, and you asked for some additional information, and we attempted to provide it for you.

But, just as a reminder, in addition to all of the complications and interactions between ACA and coverage for everyone -- all children and adults -- there are three issues that are specific to pregnancy that complicate the issue still further.

And, just very quickly, the first one is pregnancy is a temporary state, and if you are eligible based on pregnancy, at some point you will not be eligible anymore because you are no longer pregnant.

Secondly, there are different pathways that allow pregnant women to obtain coverage, which I'll describe in the next slide in a minute, but the issue related to this is that in some of these pathways women receive a different benefit package and may receive services that are limited to what is called pregnancy-related services, which I will also discuss in a minute.

But the point is that there are different packages for pregnant women through some eligibility pathways than both for pregnant women in other eligibility pathways and other adults.

The third is whether or not women receive the full benefit package -- what's considered the full benefit package -- because states are allowed to restrict coverage for pregnancy-related pathways.

The Internal Revenue Service has determined that women who are eligible through these pregnancy-related pathways do not have minimum essential coverage, which means that, one, they would have to pay a personal responsibility penalty although this has been waived for 2014 and may be waived in the future, but we don't know if it is, and secondly, that it's not considered sort of full coverage. And so they may, in fact, have both Medicaid and exchange coverage at the same time or Medicaid coverage only or just exchange coverage.

So this is more complicated than I think anybody was expecting.

Just to remind you, again, there are different pregnancy-related eligibility pathways. When I refer to pregnancy-related coverage, I am referring to the two pathways that are starred, which in some states they call them SOBRA women, but basically, it's women above the 1931 level up to whatever level the state covers, which is up to in some states over 200 percent. But they are qualifying solely on the basis of being poor or low-income and being pregnant. They are not qualified based on being a low-income family or these other eligibility pathways that are there.

A preliminary estimate, using some data that we had for the maternity chapter that we ran last year, is that there are about 750,000 women who qualify through these pregnancy-related pathways out of our estimated 1.6 million births. So it's almost half of these women.

COMMISSIONER COHEN: Sorry. Is it okay if I ask a quick-like data question?

MS. BERNSTEIN: Yes.

COMMISSIONER COHEN: Is that like a point in time? That's like in a year?

MS. BERNSTEIN: That's 2008.

COMMISSIONER COHEN: In a year, okay.

MS. BERNSTEIN: I'm sorry. I should have said 2008.

So this is a chart that I modified from a really excellent presentation that was made to CMS through their learning collaboratives, and I don't know if the audience can see it, but basically, you qualify for coverage both on your income but also on your status, your pregnancy status, when you enroll. So, depending on where you are, you know, depends on what you can get.

For qualified health plan coverage through the exchange, you can only enroll during open enrollment periods. So the first two pathways, where you're either uninsured or in Medicaid, if you were to want to have exchange coverage as well, you would have to do that during open enrollment periods.

And the last boxes sort of are very high-level advantage and disadvantages of these different pathways, but I'm not going to try to walk you through all the pathways. This is just to show you the complexity of the situation.

UNIDENTIFIED SPEAKER: Just to show it could not get worse.

MS. BERNSTEIN: Yes, it's nice to have a graphic, though. So I thought that was just a really good graphic.

VICE CHAIR SUNDWALL: I'd like to ask a favor, Amy. I'd like that graphic in a full page. I can't

read this even in the book.

MS. BERNSTEIN: Oh, okay.

VICE CHAIR SUNDWALL: So, if we could just get that, I mean that's a good --

MS. BERNSTEIN: It's in your paper as well.

VICE CHAIR SUNDWALL: Oh, it is in the paper. Thank you.

Okay, because it's not legible. Thank you.

MS. BERNSTEIN: Yes, but it is in your paper, and hopefully, will be in the chapter.

So you also asked at the November meeting to get additional information on what exactly is pregnancy-related service coverage only. Are these women really receiving the full benefit package? Are they not?

And we were not all that successful.

We did reach out to the states that we identified as having pregnancy-related service coverage only. We wrote to them. We asked what it meant. I think the most illuminating response was from the Medicaid director who forwarded it to his staff and said, I'd like to know the answer to this also.

So there is a little bit of -- okay, so we reached out. We found an additional state that probably provides these services or pregnancy-related services only. There are probably additional states.

We went through provider manuals, looking to see if there were specific codes for pregnancy-related coverage.

And one issue that arose there, which had not occurred to me before but should have, was the postpartum period. Women are covered for two months after pregnancy they're no longer pregnant. So the

issue of what is pregnancy-related coverage when you are no longer pregnant, other than complications having to do with the actual birth, is open to question.

So there were some examples of nonpregnancy-related births in the postpartum period.

I had not thought of that. So that's something to consider.

Again, our preliminary estimate is that in the seven states that we identified, or eight states if you add Louisiana now, we identified at least 170,000 women.

But, again, this is 2008 data. It's births; so this doesn't include women who were pregnant, who didn't have a delivery. There's lots and lots of caveats, but we think this is probably the minimum number of women who might have pregnancy-related service coverage only.

Obviously, as women enroll as a result of the ACA, both through the Medicaid expansions and through other, you know, exchanges, this will apply to more women.

And just to emphasize, all states at any time can restrict their package to pregnancy-related service coverage. So just because we can't identify more than eight states definitively now does not mean that there could not be more states that could roll back their services -- restrict their services -- in the future.

As far as this not being considered minimum essential coverage, again, this is regardless of whether they're receiving full coverage or not. So it doesn't matter, if you are in a pregnancy-related pathway, whether you're receiving the full benefit package; you are not considered to have minimum essential coverage.

And, if penalties are ever assessed, they would have to be paid if you are a tax-filing person and met all of the other conditions of that.

And, again, we don't know if they would be waived in the future. They have been waived for 2014.

And the big issue here is you can have both Medicaid and exchange coverage concurrently, and states are going to have to deal with that issue.

COMMISSIONER ROSENBAUM: And I'm sorry, Amy. The current Treasury reg would treat both full benefit pregnancy and pregnancy-only pregnancy benefits as not minimum essential coverage.

MS. BERNSTEIN: If you are in a pregnancy-related pathway, yes.

COMMISSIONER ROSENBAUM: Right.

MS. BERNSTEIN: So, if you're in any SOBRA pathway -- let's call it that -- even if you're in a state that provides the full package, you are considered to not have minimum essential coverage.

COMMISSIONER ROSENBAUM: So, if you were in a qualified health plan --

MS. BERNSTEIN: Correct.

COMMISSIONER ROSENBAUM: -- and you became pregnant, nobody would tell you, you had to disenroll if you're in a state with full benefits during pregnancy.

MS. BERNSTEIN: Correct.

The issue of redetermination and raising your hand -- my understanding is that is still in flux at CMS. I don't anyone is expecting this to happen. So they're not quite sure whether if you're in a qualified exchange plan you would have to raise your hand and say, okay, now I also have to have Medicaid, or whether you could just stay.

But the bottom line is, theoretically, you can have both at the same time.

COMMISSIONER ROSENBAUM: If you wanted to raise your hand.

MS. BERNSTEIN: If you wanted to raise your hand or if the plan raised your hand for you --

COMMISSIONER ROSENBAUM: That's what I'm wondering also.

MS. BERNSTEIN: -- Medicaid would wrap around for co-payments but not for premiums.

COMMISSIONER ROSENBAUM: And any additional benefits.

MS. BERNSTEIN: And any additional benefits, correct.

CHAIR ROWLAND: But let's be clear; if you are a woman who is already on the Medicaid program because you're the parent of a dependent child --

MS. BERNSTEIN: Yes.

CHAIR ROWLAND: -- none of this applies.

MS. BERNSTEIN: Correct. This is only to women who are, through pregnancy-related pathways --

CHAIR ROWLAND: Gaining their coverage.

MS. BERNSTEIN: Yes.

CHAIR ROWLAND: So it does not apply to every woman on Medicaid.

MS. BERNSTEIN: No, it's women who are through the pregnancy-related pathways that were on the second slide, which is generally women above some minimum income level, above the 1931 level, so anywhere from 16 percent to 133 percent, depending on what state you're in.

So it's not all women. It's the approximately 40 or so percent of women who qualify for pregnancy through a poverty-related pregnancy pathway.

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: Just real quick, Amy, a qualified health plan -- does that not necessarily have to have maternity services?

MS. BERNSTEIN: They do. Okay, they do have -- that's a good question.

They are required to have prenatal care with no cost-sharing. They are required to have maternity services. They can't turn women away, obviously.

The women would receive any maternity service that is determined to be part of the plan that they enroll in. So, again, they have to have prenatal care; they have to have maternity care.

But, as far as things like enhanced benefits, targeted case management or nutrition counseling or other things, that would be up to the specific plan to decide what's in there because they have to cover maternity coverage but it's not defined what maternity coverage is. Prenatal care is called out in the preventive benefits, but maternity coverage is, other than labor and delivery, up to the plan.

VICE CHAIR SUNDWALL: So that's why a woman might want also to have Medicaid -- because of those additional services they would cover?

MS. BERNSTEIN: Correct, and because they would not have cost-sharing.

So, on the slide that you can't read -- I'm sorry -- that's in your book, sort of the main -- the big-ticket advantages and disadvantages for Medicaid would be very, very limited cost-sharing and these enhanced services.

For the qualified health plan, it would be having the same coverage as the rest of your family possibly, not having to disenroll when you are no longer pregnant and, you know, keeping your doctor or keeping the network that you like.

CHAIR ROWLAND: Denise.

COMMISSIONER HENNING: To David's point, Medicaid is required under the ACA to cover

certain things that the qualified health plans don't have to cover. And that would be things like birth center services are required under the ACA but an exchange plan doesn't have to cover a birth center if they don't want to.

Access to nurse midwifery services for your delivery are required under the ACA but not under the exchange.

Things like enhanced prenatal care, like group pregnancy -- centering pregnancy groups -- that's part of the ACA but not required under the exchange plans.

The Medicaid -- I'm sorry -- yeah, specifically.

So Medicaid is actually a broader coverage.

And then, if you have only exchange coverage, when you go to the hospital and you have that 20 percent co-pay for your hospital charges, which if we -- you know. Your hospital charges end up being somewhere between seven and fourteen thousand dollars, and you're relatively low-income. That 20 percent piece can be a big hit for you, and that would be maybe why you would want both.

VICE CHAIR SUNDWALL: Thank you.

CHAIR ROWLAND: Andy.

COMMISSIONER COHEN: One thing that I felt was maybe missing a little bit in the chapter -- and, potentially, is the justification for any recommendation that we might do -- is there's no discussion of sort of the clinical underpinning of why we would be sort of concerned about this particularly.

I mean, it's really focused on well, it's a glitch; it's uncoordinated. Those are not unimportant issues, but I do think that one thing we had talked about as a Commission is that Medicaid has a unique and special

role with respect to maternity care in general.

And then I think we all know, although God knows I couldn't point to it, there is a long literature about a very direct impact between getting prenatal care and appropriate care around maternity and birth outcomes.

So I feel like that -- you know, when we are sort of evaluating priorities and other things, because God knows there are glitches everywhere we look, I feel like that piece if missing a little bit. We have a strong evidence based on that, and that should be in here.

I think what I don't yet know is whether or not there ever was -- or if there's a changing -- understanding of from the time that there were once -- you know, these original policies about pregnancy-only coverage were developed.

Is there a changed understanding about you can't separate any part of sort of maternal health from pregnancy? Has that changed?

Is there literature on that that has changed?

Did people once think that you could sort of look at someone's uterus individually and sort of every other system was different, and that sort of conception has changed?

I think about mental health issues and our understanding of how mental health would affect a birth outcome.

So, anyway, maybe too much for us to do in the very short term, but I feel like that's a piece that's kind of missing for me.

Are there changed circumstances?

Is there a changed evidence based about whether the idea of like maternity-only care or sort of pregnancy-related care makes any clinical sense whatsoever?

Anyway, that's my question.

COMMISSIONER CHAMBERS: Can I just follow up?

Andy, you reminded me of something, too, when you were talking about clinical outcomes and thinking on maternal care. I'm pretty sure that pregnancy-related services in most states are delivered outside managed care in states that have extensive managed care because it's just a very time-limited basis.

The State of California, since it's only pregnancy-related services -- as we know, one of the seven states.

And I don't know if there's anything of saying, you know, by states having to carve the population out, is there any kind of health outcomes surrounding that?

I mean, it's just another nuance of looking at what you were saying.

And then I don't know what that looks like, but I think -- I don't know if there are differences in outcomes in managed care versus fee-for-service Medicaid programs where it's delivered.

So, just a nuance of what you were saying.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: I would second what Andy said about let's try to tie this back a little bit more to the clinical relevance particularly.

And I think we should remind people that almost 50 percent of the births in America are paid for by Medicaid. This is our future. These are the children that are going to be responsible for the country should

the country last so long. These are the children that are going to be responsible for being our workforce into the future.

And that pointing out -- because when you say, well, it's this number of women, it doesn't really capture the fact that Medicaid is really a payer for almost 50 percent of all births.

So this represents -- I think that needs to be emphasized, that this is an important part of our population coming forward that will be our workforce. And then tie it to what do we know about the clinical relevance of having prenatal care, I think is important.

And I would also -- and Denise could talk to this as well, and Steven, but I'm a nephrologist. So I may be a little off-track.

But it's very hard to imagine given what we know about the interconnectivity of the human body. What is it that wouldn't be that a woman could have that wouldn't be covered under Medicaid?

I mean, they're not getting, you know, facelifts under Medicaid.

What is it that wouldn't be really a necessary thing --

COMMISSIONER ROSENBAUM: We asked this question in 1983 when the language first appeared.

COMMISSIONER GABOW: Well, we could ask --

COMMISSIONER CHECKETT: And we asked last month when you weren't here, and we still don't have an answer.

COMMISSIONER ROSENBAUM: The answer is we can't think of anything, and we couldn't think of anything then either.

COMMISSIONER GABOW: And I think we should emphasize that, too, that from a clinical perspective, given what Medicaid covers, that it doesn't cover elective things, that it is very hard to understand given our current understanding of the relationship of all mental and physical physiologic pathways, what would not affect the fetus?

You know, I just can't think of anything.

COMMISSIONER ROSENBAUM: I can tell you there's the cosmology answer, and then there's the practical answer.

So you're totally correct, clinically.

And 30 years ago, when the expansion group first appeared, there was a mild ruckus about the language. And the answer we got was that the politics of the expansion compelled the language, and what was compelling the language at the time was abortion.

CHAIR ROWLAND: I think we need to get back to the discussion on the recommendations, which we haven't let Amy really go through.

But I also think that the other piece that we ought to make sure we add into this context is that Medicaid has an interest not just in the pregnant woman but especially in the outcome for the birth because, obviously, we know one of the huge costs that Medicaid incurs is neonatal intensive care. And so really looking at that part of the equation is important.

Oh, now I have Mark and Denise.

COMMISSIONER HOYT: Just real quick, this study is pretty old at this point, but if you've never found it -- Alabama did a waiver, I think, about 15 or 20 years ago in prenatal care. I think two of the

measures they looked at were percentage of births that went full term, and then they defined low birth weight babies somehow at 1,000 grams or whatever line they picked. And they got a waiver to provide coupons for diapers, baby food, all sort of other things, circling back to the impact on prenatal care, and they ramped up the amount of prenatal care, access to OB/GYNs or to just better -- more visits and all the other things you do.

And it was pretty impactful. It's kind of a classic study.

MS. BERNSTEIN: Can I just ask a clarifying question, though?

Is your question more what's the difference between women who receive -- in outcomes, between women who receive pregnancy-related services only and women who don't, or what is the effect of prenatal care in general -- because all of the women are getting covered, either through the exchange or through Medicaid.

So, if -- I mean, we could try to compare --

COMMISSIONER COHEN: All of them are eligible to be covered, but we -- I mean --

MS. BERNSTEIN: Okay.

EXECUTIVE DIRECTOR SCHWARTZ: The issue in this chapter is not about the quality of the prenatal care or the pregnancy coverage for women in those seven or eight states because that is clearly covered.

The question is, what else?

As I think Amy pointed out at the last meeting, you know, one could imagine a scenario in which women in those seven states have excellent, perhaps better, pregnancy outcomes and outcomes for the kids because that is not at issue. The issue are things that they're not getting.

I think the latest we heard from New Mexico -- the Medicaid director told us, for example, it would be possible that a pregnant woman under the pregnancy pathway with restricted services would not get eyeglasses.

COMMISSIONER ROSENBAUM: And, again, I was not being facetious before. The issue in 1983 was abortion. That was the issue.

And so the term, pregnancy-related services, was used to assure because if there was a service that is not pregnancy-related, even a medically indicated abortion. Nobody really intended at the time that women not get their broken arm set, not have cancer treated, not have dental care or eyeglasses.

I think we've drifted into this area precisely because nobody really ever memorialized the consequences of the term, pregnancy-related, and it's been given a wider berth than it was intended.

And so, in that sense, I think we're totally clinically appropriate to say that anything that is necessary to the health of the pregnant woman and a healthy outcome of her pregnancy should fall into the pregnancy-related category, and therefore, the pregnancy-related category, just like EPSTD, should encompass all benefits, all state plan benefits. That may be a better way of doing it than trying to take on the term, pregnancy-related, itself.

EXECUTIVE DIRECTOR SCHWARTZ: That's what the recommendation was.

CHAIR ROWLAND: Okay, Burt and then Mark.

COMMISSIONER EDELSTEIN: And given that there is a recognized relationship between pregnancy outcomes and oral health, Sara, your comment needs to be amended only slightly in that there are a number of states that do not consider --

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

COMMISSIONER EDELSTEIN: Right.

COMMISSIONER ROSENBAUM: Well, except in the states that don't cover adult oral health.

COMMISSIONER EDELSTEIN: That's the point.

CHAIR ROWLAND: Yes, Burt wants them to cover.

COMMISSIONER ROSENBAUM: Yes.

COMMISSIONER EDELSTEIN: There are a couple of states that have added adult dental benefits exclusively for pregnant women -- three states. But I think we could make the argument on a clinical basis that there is an example of a clinically related important health service for pregnant women that, is in many states, not covered.

COMMISSIONER ROSENBAUM: Well, the analogy then is to EPSTD.

CHAIR ROWLAND: I think we are confusing two things here. We're confusing what we think a woman who qualifies through the pregnancy-only pathway should be entitled to as a benefit package versus the how does this transition work between the exchange and Medicaid, which is a different issue than how the pregnancy-related option works.

And so I think if we let Amy go to our recommendations we'll see that we're going to be looking at both of those issues.

MS. BERNSTEIN: Okay. So I think we don't need this one anymore.

So the proposed recommendation for your consideration -- and I'll show you a scaled-down version of this in a second -- is that Congress should require full-benefit Medicaid for women enrolled through

pregnancy-related pathways with continued flexibility for them to provide enhanced pregnancy-related services, which basically gets away from -- it basically changes the definition of pregnancy-related, to get rid of it, so that you don't have to deal with the minimum essential coverage issue. They're getting the same services as everyone else and all other pregnant women in the Medicaid program.

CHAIR ROWLAND: It simplifies things.

MS. BERNSTEIN: And it simplifies things.

I mean, the intent of the ACA was to consolidate six eligibility pathways, and they do, except they really don't because two of them are now not considered minimum essential coverage.

So, by keeping the definition that you described as a historical artifact, they're confusing and making things more complicated and classifying something that's not minimum essential coverage, when maybe it is minimum essential coverage, but it's classified as not.

So, for your consideration.

If that is to -- and the CBO estimate is in their lowest bucket. So they think it would have some cost implications but, again, in the smallest bucket that they provide.

An alternative recommendation would be to not deal with the minimum essential coverage and just say that women below 100 percent of the federal poverty level, who are in pregnancy-related pathways, should receive the full benefit package just so that they would receive full benefits like women in the alternative benefit package. It would not be the same package, but it would be full benefits, full maternity benefits, with no cost-sharing.

So this gets away -- this deals with the equity issue of women in Medicaid pathways receiving different

coverage but doesn't deal with the minimum essential coverage issue because women below 100 percent of the federal poverty line are not eligible for the exchanges.

CHAIR ROWLAND: Coverage in exchanges.

Okay, Judy, Mark was first because I cut him off before. So we go Mark, Judy, Trish, Sara, Denise.

COMMISSIONER HOYT: Do we know what the CBO assumptions were -- the cost drivers behind their numbers the way they saw it?

MS. BERNSTEIN: They have their baseline estimate.

My understanding is that they were not aware that the pregnancy-related pathways were not minimum essential coverage. So I don't know whether they made changes to their baseline or what their assumptions were.

I think their assumption was that if some additional services were provided it would cost more and there would be costs to coordinating benefits.

CHAIR ROWLAND: And the cost estimate is the same for both recommendations?

MS. BERNSTEIN: They didn't give us a cost estimate for the second recommendation because it's in the lowest bucket, but it's less than the preceding recommendation.

CHAIR ROWLAND: Less than, okay.

Judy.

COMMISSIONER MOORE: Nice job, Amy.

I support option 1 strongly based primarily on the fact that I believe that national policy should reflect the easiest and best access and coverage possible for low-income women. And the states get to choose that --

what low-income means in their state; that's important.

But the outcome that we all want across the country is healthy babies. Healthy moms and healthy babies.

And I think we see a situation where the ACA and Medicaid and the built-up statutory and now regulatory, and I guess past regulatory, pronouncements have produced a complexity that I just don't believe that most people would like to see when we're dealing with low-income pregnant women and when we want to see healthy babies across the country.

So I think it's just important for us to make a statement here and do away with at least a little bit of this complexity and fix something that's been a problem even before.

I do also think that -- and the CBO doesn't ever really take into consideration, in my view, some of the costs associated with administering these kinds of things.

I can picture clients, beneficiaries, providers, state officials sitting around a table, trying to figure out how this is going to go for some individual person who has been covered by an exchange -- has been in Medicaid and now is supposed to go in an exchange, and who's going to pay what. That, to me, is a cost, too, and it certainly flies in the face of a simplicity that we would all like to see a great deal more of in this program.

So, my view.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: Well, I obviously like the policy here, but I think we have to consider the cost to states.

And it does bring us back, as much as we don't want to come back, to the definition of what is benefits

for pregnancy-related women. If we're right, that it's everything related to the mother's health, then it's not a problem. But, without that information, it seems to me this has the potential to pass on costs to those states.

And I don't know if we had feedback from those states or where we stand.

MS. BERNSTEIN: We were in contact with all seven states. Not all seven answered.

Several of them just quoted back to us what they do, without further explanation.

Others pointed out specific things that they would not cover -- for example, glasses, that they would have the opportunity to do that.

In one state, influenza would have to be considered.

COMMISSIONER HENNING: In the postpartum period? MS. BERNSTEIN: These are the ones in the postpartum, the 60 days postpartum, would not be covered.

The provider manuals provided lots of clues on this.

One state offered to do some runs for us to look at what would be the experience of similarly situated pregnant and non-pregnant women. They just suggested that. We said, sure, why not? But we never got those.

So we're a little bit at the mercy of the states in doing that.

I think what happened as a result of that inquiry is we got more tidbits of information that suggested that there is a difference. The extent to which that's a difference, either in terms of what people are not getting or what they're on the hook for -- what they are getting, but they're on the hook for, financially -- I don't think we can find out further.

But what we did find is, yes, there is some difference.

COMMISSIONER HENNING: But I feel more comfortable with the answer.

MS. BERNSTEIN: And we also reached out to others -- you know, advocacy groups -- and said, can you give us any examples?

And we haven't received anything from them either because, I mean, a lot of it is up to the physician. And, you know, probably most physicians would consider everything pregnancy-related, but it's really hard to document that.

CHAIR ROWLAND: Okay, I have Denise. Then I have Sara, Donna -- I have everyone on this side of the table.

[Laughter.]

CHAIR ROWLAND: Denise, you start.

COMMISSIONER HENNING: So I'm sitting here trying to come up with some things that might not be considered pregnancy-related even though in my view, since I'm dealing with the whole person, I think everything, if you're pregnant, is pregnancy-related. So I'm just going to say that to start with.

But they might choose not to cover an ear infection. They might say, you have to pay out of pocket for that; you have to buy your own meds for that.

They might choose not to cover cholestasis if they have a gall bladder problem that tends to be aggravated by pregnancy. But the person that's handling them might say, let's see if we can get you through until after the delivery; then we'll take care of it.

But then they're in the postpartum period and it's not pregnancy-related. So they may choose to let her suffer and go back and forth to the ER.

That same person who now is in an expansion state could probably get her gall bladder taken care of.

So that's the basic unfairness of it all, which you did a really good job of pointing out, I think, in this chapter, especially with people in the expansion states -- that if they were not pregnant, they would have access to regular Medicaid where they would have a lot better coverage.

And, if you're going to limit it because you're pregnant, it just really doesn't make sense.

And one of the things I was going to say before, that really has nothing to do with the point I just made -- you know.

I just wanted to share a personal story of a patient of mine, who was with me on her sixth pregnancy. She had never had a full-term delivery, never. The farthest she'd ever gotten was 32 weeks; that baby survived. She had two children that died because they were born prematurely. She had a uterine abnormality.

We got her into prenatal care early, as soon as the pregnancy test had a faint pink line on the second one, and got her to maternal-fetal medicine. She got progesterone therapy.

In this particular pregnancy, she delivered at 36-plus weeks, which technically is still late pre-term, but for her it was wonderful. This baby had to spend one extra day in the hospital. It did not go to NICU.

And that kind of care and that kind of identification of problems before they get bad, and getting people into care early -- that's why maternity coverage is so important, and that's why it needs to be, and remain, an essential health benefit under the exchange program.

CHAIR ROWLAND: Okay, Sara, Richard, Sharon, Donna.

COMMISSIONER ROSENBAUM: Well, I want to say two things. One is I'm totally in favor of

bullet number one, but number two, we've got to get much clearer in our language here.

In Medicaid, we could take one of a couple of different positions. One is that pregnancy-related ought to equate with all items and services under the state Medicaid plan, okay, as opposed to some subset thereof. That's the proper language.

That brings us to the second issue, which is Burt's issue, which is how about states that want to go beyond what's otherwise covered under the state Medicaid plan for their pregnant women and do things that are not done for other eligibility groups. And that's, of course, known as waiving comparability.

So what we would really want to say is that we want to equate pregnancy-related services with all services covered under the state Medicaid plan while retaining the state option to waive comparability in order to provide additional services not otherwise covered under the plan.

My allusion to EPSTD before was simply if we want to compel dental benefits we're going to have to go beyond the state flexibility.

And all of this, in addition to cleaning up the language to be consistent with what Medicaid actually says -- there's nothing called full Medicaid coverage. So we have to sort of move away from that language.

But, beyond that, the moment that this is reclassified as minimum essential coverage, I feel very strongly that we also have to say that if a woman becomes pregnant during a year, when she is enrolled in a qualified health plan, this cannot be the basis. The fact that the pregnancy coverage is minimum essential coverage cannot serve as the basis for requiring that she report her pregnancy or face a potential disenrollment from her qualified health plan because suddenly she's a dual enrollee with minimum essential coverage.

So I think we've got to just get clear in the language and bring in this caveat that CMS has left hanging

over, which is the impact of being in a more generous state and becoming pregnant midway through your health plan enrollment, because we want to encourage states certainly to keep more generous Medicaid coverage because it's point-of-service coverage.

If we allow people to be disenrolled from their qualified health plans because they're pregnant and put back into a pregnancy category, states will start dropping their pregnancy category. So we've really got to close that loop as well.

CHAIR ROWLAND: Okay. All right. Then, Richard.

COMMISSIONER CHAMBERS: I was going to ask a question, and Sara just raised the point and answered it.

CHAIR ROWLAND: Okay.

COMMISSIONER CHAMBERS: Or, raised the question.

CHAIR ROWLAND: Okay, then Donna.

COMMISSIONER CHECKETT: Totally agree with Sara's point and the others of the commissioners in terms of this is the recommendation that I support, but I don't fully understand when we say enhanced pregnancy-related services to those women. What are we talking about there?

MS. BERNSTEIN: So, for example, in the alternative benefit package, they are required to have essential health benefits. So they have to have maternity coverage, but again, that's how they define it, which wouldn't necessarily include some of the special things that the pregnancy programs have, like targeted case management and other things that were waived for comparability. So they can provide these services to pregnant women that they don't have to provide to other women.

So, instead of saying, okay, now we're going to put everybody into the alternative benefit package, which may not have these special pregnancy-related services, we're allowing the states to give them those pregnancy-related services that we give currently to our pregnant women.

Did that help?

CHAIR ROWLAND: Sharon, Robin and Steve.

COMMISSIONER CARTE: I just wanted to note I fully agree with what Judy stated earlier because I am one of those state officials that's already been around the table when we're having a discussion about the complexity of these eligibility decisions. Just that in and of itself is a great concern.

As Trish knows, I'm usually one of the ones that will first think about the state implications, but I just feel strongly that what's at issue here is the outcome for healthy mothers and children and that states, by retaining a policy that doesn't let mothers get a full Medicaid-related benefit -- that it's just very short-sighted and probably is having a negative effect.

CHAIR ROWLAND: Okay, Robin.

COMMISSIONER SMITH: To put a fly in the ointment, I'm sorry, but Andy actually brought behavioral health. Is that something that would be covered under what we're talking about -- because that is directly related, I think, to a lot of complicated birth outcomes.

And I think we could show -- hopefully, somebody has statistics on the outcomes. And it's not just NICU stays. It's that when a baby is born at a pound, 7 ounces, 25 weeks; then you have a lifetime of both medical and developmental issues.

MS. BERNSTEIN: I think most of the enhanced benefit packages I've seen include some kind of

behavioral health for the mom -- depression, postpartum depression, things like that.

But what -- I'm sorry.

COMMISSIONER SMITH: That's not what I'm talking about.

MS. BERNSTEIN: What?

COMMISSIONER SMITH: I'm talking about behavioral health issues that impact mom's behavior during the pregnancy.

CHAIR ROWLAND: Substance abuse.

COMMISSIONER SMITH: Either substance abuse --

MS. BERNSTEIN: Oh, yes, definitely.

COMMISSIONER SMITH: -- or a disorder. Anything that would --

MS. BERNSTEIN: That's included in most of the enhanced benefit packages as well as -- and it would be what -- if you were in the alternative benefit package, it would be whatever is included there.

For the mom's, they have targeted case management and risk assessment and a lot of substance abuse and behavioral health counseling and treatment.

COMMISSIONER SMITH: Just personal experience -- virtually every child I've had and have adopted -- you could go back to mental health issues. And they are so complicated --

MS. BERNSTEIN: Absolutely.

COMMISSIONER SMITH: -- and costing the states so much money now -- the children.

CHAIR ROWLAND: Steve and then David.

COMMISSIONER WALDREN: Can I piggyback on that?

So you talked about those being in the advanced.

So do we know; are those -- in the pregnancy-related services states, are those mental health things covered?

And in those that are on a qualified health plan in the exchange that have pregnancy-related services, or maternal care, are those things covered there?

MS. BERNSTEIN: Well, again, I think -- in the states that have pregnancy-related service coverage only, in the seven or eight states, my understanding is that most of them would have targeted case management and behavioral health, risk assessment and treatment because they're focusing specifically on the pregnant women and those are big issues. You know, there are a lot of issues in these populations.

What's on the alternative benefit package -- I mean, we don't know what a lot of them have yet, but one would -- I would hypothesize -- I'll go out on a limb and say I would think they would have less generous behavioral health benefits than the enhanced pregnancy packages would have because it would be whatever is required as an essential health benefit. And mental health is one of them, but how exactly it's provided we don't really know yet. That would be up to the individual state and their package.

CHAIR ROWLAND: Amy, we're talking about a policy in seven states, correct?

MS. BERNSTEIN: Or more. Seven or more states.

VICE CHAIR SUNDWALL: So it's only for those seven.

CHAIR ROWLAND: But if we recommend full Medicaid coverage, would those seven states have a problem? Would they say, oh, we're going to drop pregnancy-related coverage because of it?

I mean, what is a possible consequence of this?

We know what the benefit is if we go forward. But, what are the consequences?

MS. BERNSTEIN: Well, the consequence was if there are things that they're not paying for now they would have to pay for it.

CHAIR ROWLAND: But not that they would stop covering these women.

MS. BERNSTEIN: They can't stop covering the women.

COMMISSIONER ROSENBAUM: [off microphone.] No, but they could stop [inaudible].

MS. BERNSTEIN: Yes, but up to 138 they cannot stop.

CHAIR ROWLAND: Okay, Steve.

COMMISSIONER WALDREN: So I guess what I'm struggling with -- and I agree with Denise's commentary on that particular patient and the great outcome, but I see that as prenatal care and being pregnancy-related.

So the only thing I heard that is not covered is eye glasses, which is not going to really change an outcome from the standpoint of NICU stays and all these other things that we really want to improve.

So I guess I'm struggling in the fact that I don't see any -- I've not heard any evidence to say that we'll actually improve some of the outcomes, but I do think this is a vulnerable population.

And I guess I'm willing to support the recommendation if it's tied with an evaluation of what is the impact if this recommendation is taken up. Do we actually show that we're actually making an impact on those things that we want to make an impact on -- again, healthy babies, healthy deliveries, those types of things?

CHAIR ROWLAND: I do think one of the problems here is that we don't know that there's that

much difference between this scope of benefits or not, but we do believe in trying to both streamline, simplify and provide better stability in coverage for vulnerable populations.

And I think from a Medicaid perspective we need to emphasize that, given the income range of children that are covered by Medicaid, the children of these women are likely to be Medicaid. And we are investing in healthier babies, as Judy said, that will be on Medicaid's rolls. And, as Robin noted, many of them can be on the rolls for years and years as high-cost children if they're not getting adequate care to the mother during the pregnancy.

That, I think is our strongest rationale for our recommendation.

And so I will take -- David has a quick question, and then I'm going to Donna and Patty, and then we should really move on.

VICE CHAIR SUNDWALL: Yes, I'll be very brief.

I would be very inconsistent if I didn't support the intent of this because of my interest in population health and public health. And, clearly, as Andy said, there's beaucoup evidence of the benefits of good prenatal care.

But I just want to have the commissioners be aware that this is the third recommendation we've considered with a cost estimate of several -- it's not huge, but in Washington terms, again, if we go forward with this, we're going to be recommending yet again millions and millions more to improve the coverage for a small group of folks here. I just think we need to be sensitive to that.

And I also think given, as Sara pointed out, the sensitivity around maternal and child health issues in general, we have to be careful how this is worded.

And I think -- was it Andy? You wanted more evidence, more clinical argument for this as well as just because it's the right thing to do.

CHAIR ROWLAND: Okay.

COMMISSIONER GABOW: I think that even if -- I don't think we should put on this that they need to study it because even if there's no difference in the care that women are getting in pregnancy-related or not I think the wording that Sara put in, to your point, Diane, creates administrative simplification, and that's important, and clarity for the states. I don't think we should add more cost by saying prove that it's different.

They're probably getting 95 percent of what they would get anyway. This just makes it easier for everybody to get that. And I think that's the strongest argument.

Let's not make things more complicated for unnecessary reasons.

CHAIR ROWLAND: Okay, Donna.

COMMISSIONER CHECKETT: Just a really quick observation as well is that one of the things that concerns me about the current situation is that we really have a potential for some citizens having qualified health plan coverage and then actually having less coverage, worse coverage, because they raised their hand and said I'm eligible for Medicaid and they're moved to another Medicaid program. That's what worries me about the current situation.

And so I just want to point that out. So, thank you.

CHAIR ROWLAND: Okay.

COMMISSIONER CHECKETT: [off microphone.] Don't lose sight that that's the issue. [Inaudible.]

CHAIR ROWLAND: All right, I think we've tortured Amy long enough. And so we're going to take a 10-minute break and then be back to continue our discussion of program integrity issues.

[Recess.]

CHAIR ROWLAND: Okay, if we can please reconvene so we can get back on schedule.

We are going to start right now with our discussion of the program integrity issues with regard to the ACA. What we're going to do following Moira's presentation is to take our lunch break and return and do supplemental payments after lunch so that we can have the full discussion that I know we want to have on that topic.

So Moira, take us to Tab 6.

Session 5:

Review of Draft Chapter for March Report: Medicaid

Eligibility Changes: Program Integrity Issues

* MS. FORBES: Yes, and I'm a Yankee, so I'll talk fast. I know it's been a long morning.

So today we're going to talk about the draft chapter for the March report, eligibility changes, program integrity issues. This expands on some of the issues that Veronica mentioned the first thing this morning in the context chapter. It rounds out our ACA section but there are no recommendations. It's just a background chapter for the March report.

So for the most part, the draft that you've had to review reflects what I presented in November. I'll just quickly go over some of the key points again.

As we've discussed, obviously, the ACA mandates many changes to Medicaid and CHIP eligibility

processes and policies to simplify enrollment and increase the share of eligible persons who enroll. The goal of many of these changes is to allow states to make determinations of eligibility and ineligibility more accurately, more quickly, and at less expense. A lot of these changes affect the application and verification process which can, in turn, have impacts on program integrity.

At the same time, the ACA provides states with some new tools which should help, such as broader access to third-party sources of data through the Federal Data Shared Services Hub. This may help promote accuracy as well as efficiency.

So the chapter discusses four specific changes to the Medicaid eligibility process that may have an impact on program integrity and some of the strategies to monitor these impacts in the short term. The four areas discussed in the chapter are self-reported information and the reasonable compatibility standard; post-enrollment verification; administrative renewal; and coordination with exchanges.

Just really quickly, as we discussed in November, the first item about self-reported information, this is the new requirement that Medicaid and CHIP must largely rely on applicant self-attestation of program eligibility, which will be verified through trusted sources, instead of paper documentation at both application and renewal.

Post-enrollment verification has to do with the state option to determine eligibility using self-reported information and then validate that information after eligibility has been granted.

Coordination with exchanges refers to the sharing of eligibility information among Medicaid, CHIP and the exchanges. This is obviously a new component of eligibility policy because the exchanges are new. This requires protections to ensure the accuracy and security of information shared between these programs.

We did not discuss administrative renewal -- or I did not discuss administrative renewal when I presented in November. It was part of our discussion and so we added a section to the report. State agencies must now use available information, such as third-party databases, and information otherwise known to the state -- they may know it from a person applying for another program such as SNAP or other kinds of assistance. They must use that information to facilitate the annual redetermination process.

If the state does not already have information to make a redetermination decision they have to provide a pre-populated enrollment form and send it back to the eligible and give them at least a month to respond. Administrative renewal has been used in the past by some states but not on a wide scale like a lot of these other changes. And so we'll need to carefully monitor the impact of all of these changes to make sure that they are not having an adverse impact on program integrity.

So the adoption of new processes to support automation and real-time eligibility adjudication will require new strategies to ensure program integrity. CMS has implemented two strategies to support the development of appropriate methods to ensure the accuracy of eligibility decisions under the new rules.

First, states must develop a verification plan and submit it to CMS, which will assess the plan for compliance with the new eligibility regulations. This plan must describe how the state will establish verification procedures for various factors of eligibility such as income, residency, age, and household composition, particularly where there is flexibility for states. For example, states can choose to accept self-attestation of information without additional verification or it can require certain types of additional verification. The plan that is submitted to CMS should just indicate which the state intends to do. The verification plans -- I actually don't know if they've -- I believe they've all been submitted to CMS. Many of

them are now posted on the CMS website. Those plans will serve as the basis for future eligibility quality control audits.

CMS is also implementing a new 50 state pilot program strategy that will replace the Payment Error Rate Measurement and Medicaid Eligibility Quality Control Programs for fiscal years 2014 through 2016. The pilots are designed to provide states and CMS with timely feedback about the accuracy of determinations based on the new rules and help support the development of improvements and corrections where problems are found.

So the initial pilot in each state will focus on the MAGI-based determinations. All states will sample, review and report on 200 Medicaid and CHIP cases that are determined eligible or ineligible between October 1 -- just past -- and this coming March 31st, the first six months of the period where these new rules went into effect. All states will participate in this pilot for this three-year period and they will conduct four pilots over the three years.

While we are interested in many aspects of the ACS implementation, from a program integrity perspective I think there are a few key issues that we will want to monitor. The pilots I just described will provide some information on these issues. We will also be keeping an eye on are these things as part of our regular monitoring of what's going on in the states and what's going on with the ACA.

So three issues in particular to keep an eye on the extent to which centralized data sources and systems, the hub and other connections that states have developed to get access to timely information, the extent to which these are actually providing sufficient, timely, and reliable information for states to make accurate eligibility determinations. There's a lot of new systems. Some of the data sources that are now allowed have

not traditionally been used to make Medicaid eligibility determinations and we just don't know how satisfactory they are going to be.

We will also look at the accuracy and efficiency of program assignments and hand-offs among Medicaid, CHIP and the exchanges and eligibility for advanced premium tax credits. I think partly in our pregnancy discussion we just had there's a discussion of: if you're in one program and something changes in your life, if your income changes, if your pregnancy status changes are there responsibilities that you have, things like that. As well as at the time of initial application at redetermination, are you ending up going -- if you go through one door, does it send you into the right hallway?

So those are some new questions and things that we'll want to pay attention to.

And finally, we will want to look at the extent to which other ACA-related eligibility policies, particularly where persons in certain groups may be eligible for an alternative benefit package, are the decisions being made properly so that people are receiving the benefits to which they're entitled?

What we learn about these issues over the next year may suggest areas that should be incorporated into ongoing eligibility program integrity activities. It may suggest areas where additional verification or coordination procedures should be implemented. These are things we'll have to learn more about, I think, before we can sort of make any kind of informed recommendation.

The three year pilot period will also provide an opportunity to revisit the overall eligibility program integrity framework and adapt it to better reflect the new system. As I said, this includes multiple access points and a continuum of coverage across programs.

Traditional eligibility quality control programs have focused solely on individual programs. They

look at Medicaid, they look at CHIP. For example, if there's an error in a program -- if someone is eligible for CHIP, but they are in the Medicaid program. You look at them in the Medicaid program and find out they should have been in CHIP, that doesn't really matter. They're an error as far as Medicaid is concerned and they're nothing as far as CHIP is concerned for accuracy.

But now that we're really trying to make sure people are winding up in the right program, one thing that you might want to think about in the future is if we're going to support a continuum of coverage, the policymakers should reconsider how to evaluate errors in program assignment.

Also, because MEQC and PERM are very focused on state actions, they have traditionally excluded from review enrollees whose eligibility is based on an outside determination. If a state delegates responsibility for determining eligibility on the basis of disability to the Social Security Administration, if they just accept those determinations, those are not included in their reviews.

But what's not clear is what do we do with the exchanges, whether it's a state exchange, whether it's a Federal exchange, those sorts of things. So again, I think we'll have to learn more about how it's working and then take the opportunity to think about how can we incorporate all of these policy changes into a new sort of master eligibility quality control program.

So that's a quick summary of the chapter. I certainly welcome your ideas for ways on -- your ideas for ways to strengthen the chapter. I appreciate the feedback we've gotten from a couple of folks already, particularly if you have -- if there's anything we can further clarify or anything on tone or clarity, I appreciate it.

CHAIR ROWLAND: Trish, then Patty.

COMMISSIONER RILEY: At least we didn't have to do this after lunch. This is always a tough

topic and you did a great job summarizing it, I think.

But I think it needs a little bit -- the piece needs a bit more context, particularly around how we make assumptions about the streamlining of eligibility is simplified. But I think we have to be very clear that there's still the legacy system, that MAGI isn't the entire Medicaid program. And so states -- in fact, it's not simpler, it's tougher in many respects because you have two programs that you have to operate.

I can't talk about program integrity, which is always at the back end, without talking about how little we talk about the front end. So I would like to see some discussion, at least in the narrative, about program integrity -- you need more attention to program management administration to avoid some of the programs that program integrity is designed to address, program integrity gets a 90/10 match, state coordination with the exchanges, the policy development, the oversight that's required is still reimbursed at 50/50 and yet the state responsibilities have increased under the exchange.

So I think we have to be careful as we frame it that this is not some panacea of simplicity but that it's in a bigger context of complexity.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: In that regard, too, I think we want to always keep the piece that we've talked about before, that when issues are identified that there should be a feedback loop that goes back to say why did this happen? Was the regulation too complex? Was this, you know, unclear? Rather than simply saying wow, this is a good way to get penalty dollars in the door.

I think there has not been the same feedback loop that we have in clinical medicine. If 100 people are all having the same problem, it's probably not 100 providers who are intending to do harm. There's

something wrong in the system. I think we have to emphasize that piece. We've talked about it before, but I don't think we want to forget that.

CHAIR ROWLAND: Judy.

COMMISSIONER MOORE: A question. It almost seems from the descriptive stuff that you have here and that I have read that CMS is starting this new sample and new demonstration, if you will, and a long time is going to have to transpire before we really learn too much. And that goes to Patty's point about mid-course correction.

Do you sense that we, or anyone else, will be able to, in six months or 12 months, take a look at where things have gotten? Or how do you see that playing out.

MS. FORBES: CMS will know. The states are being asked to sample between October 1 and March 31st and to complete the reviews and report to CMS by June, which is actually really fast. I don't know when CMS will share that information with the rest of us but I think their intent is to begin -- I mean, they've stated an intent to begin a new rulemaking process around program integrity the end of next year. So I think that what they learn --

COMMISSIONER MOORE: Using this information, presumably.

MS. FORBES: -- they are going to try and use very quickly. But they want to get the information before they start making changes. That's my understanding. That's what they've said.

CHAIR ROWLAND: So I think we should clearly put on our schedule to have CMS report back to us on how this is going, whether at our June meeting or just to provide us with information that we can share with the Commission members, and that you will continue to monitor.

COMMISSIONER MOORE: As well as the states, because they may have some very strong opinions of some of these kinds of things, too, that would have to do with Medicaid-exchange interaction that will be harder for CMS to comment about.

CHAIR ROWLAND: Well, also one of the concerns I know that Congress has had is whether the verification system will actually be adequate enough to make sure that the appropriate people are getting coverage and not inappropriate people. So I think that clearly is an issue that the Congress is anxious for everyone to watch.

And I would also emphasize Trish's point that I think has been a long-standing discussion here of the fact that an ounce of prevention is worth a pound of cure and that program integrity needs to also have good program management support. One of the things we may really want to look at down the road is the support for the administrative functions of the program.

VICE CHAIR SUNDWALL: [off microphone.] Absolutely.

CHAIR ROWLAND: Denise?

COMMISSIONER HENNING: It's sort of along that line. What do we know about how set up the states are to collect the information and to make the changes to their IT systems to get the correct information that's now required that wasn't required before? I mean, are all states kind of already there as far as the computer systems? Or is there a lot of work still to be done?

MS. FORBES: So, all states were required to make a lot of changes and to implement the MAGI requirements, whether or not they did the Medicaid expansion. CMS did offer -- well, states can get 90 percent match to implement new IT systems and CMS did release guidance a few years ago, trying to be very

clear that implementing all of these eligibility changes requires a lot of new policy and new staff and all of these kinds of things and that they considered a lot of that related to the implementation of these new systems, and therefore would quality for a higher match -- to Diane's point, that they did try and provide, at least during this transition period, some additional financing for states to do that.

I think because so much policy has been -- it takes longer to develop than people want, I think that -- and certainly we've seen changes in things like connections to the Hub and connections to the Federal Exchange and things, it's still ongoing. And at some point that enhanced funding, some of that enhanced money will run out.

But I think there's been some -- I think there have been pretty significant efforts to help the states get up to speed.

CHAIR ROWLAND: Great. Okay, well thank you very much.

What we're going to do now is to take our lunch break at 12:10 and reconvene at quarter of one to take up the supplemental payment chapter. So we stand adjourned until 12:45.

[Whereupon, at 12:11 p.m., the meeting was recessed, to reconvene at 12:45 p.m., this same day.]

AFTERNOON SESSION [12:55 p.m.]

CHAIR ROWLAND: Okay. If we could please resume? We're now going to turn to look at one of our major payment issues and that's the role of supplemental payments that are non-DSH payments and Jim is going to lead our discussion. We are at now Tab 7.

Session 6:

Review of Draft Chapter for March Report:

Non-DSH Supplemental Payments

* MR. TEISL: Thank you and good afternoon, everyone. So the goal for today's session is to again discuss non-DSH supplemental payments in the Medicaid program and the limitations of Medicaid payment analysis if we're unable to account for these payments, particularly at the provider level.

We've covered a lot of the descriptive information in past sessions, so today I'm really going to focus on an option for a possible recommendation for improved data collection and its associated rationale. But I have to do at least a little bit of background.

Non-DSH supplemental payments, again, are in every way that we've been able to determine thus far, an important component of total Medicaid payment, particularly at hospitals, and we see quite a number of states where at least in CMS 64 reporting they look like a pretty big important -- a pretty important part of payment for nursing facilities as well.

States reported about $22 billion in these non-DSH or UPL supplemental payments in the aggregate in fiscal year 2012. Data regarding the non-DSH supplemental payments, and also some -- we've talked in the past about some of the financing mechanisms states use are not readily available at the Federal level, so we

can't determine total payment to providers, and therefore, we're unable to start to look at the effects that payment policies have on different program objectives.

Again, when we talk about non-DSH supplemental payments, we're generally talking about lump sum payments that are made to fill in the gap between what Medicaid pays in its rates and the upper payment limit, which is a reasonable estimate of what Medicare would have paid for those same services.

We distinguish them from DSH payments, which as Veronica mentioned this morning, are also lump sum payments, but are statutorily required to make hospitals -- are statutorily required for states to make to hospitals that serve higher percentages of low-income individuals.

Again, even from limited aggregate data that we have, it's clear that these UPL payments are very important to providers and states. The CMS 64 data show that even if you look at them as a percentage of all Medicaid payments, including DSH, nationally they look like about 20 percent of total payments to hospitals. In individual states, of course, there's a big range, but we see states where their CMS 64 reporting suggests that these are even more than half of the total payments that they make to hospitals.

So for individual hospitals, and again in some states' nursing facilities, they undoubtedly have a major impact on those providers' bottom lines.

The work that we've done in the past was largely descriptive and we've provided some hypothetical examples. As we talked about a couple of meetings ago, what we tried to do is actually go out and collect data from several states to see if we could put some real numbers behind the thing that we suspected to be true, that being that these supplemental payments, in fact, are a big part of total payment, and whether or not you're able to include them in payment analysis would have a big effect on the results that you see.

As a reminder, the states agreed to participate anonymously in order to allow us to analyze actual state data without drawing policy conclusions specific to any individual state program. It's also important to remember that the goal was to see if we could actually demonstrate the effect of these payments on payment analysis. I'm going to emphasize this a couple times. It was not to assess payment adequacy in the states that participated.

We didn't do any sort of independent validation of the data they provided. Where possible, we used public data sources, such as Medicare cost reports, to estimate Medicaid costs. That introduces some limitations that we would have to think more about if we were actually trying to conduct payment adequacy analyses.

What we were trying to do is show how the inclusion or exclusion of these non-DSH supplemental payments affect what we see when we look at Medicaid data. So this slide is relatively self-explanatory. In three of the four states for which we were able to collect data, these supplemental payments represented a large portion of total Medicaid payment, roughly 30, 40, and even 50 percent.

We targeted these states specifically because they use these things, so we're not trying to suggest that these four states are perfectly representative of the Medicaid program nationally. That said, we don't think that these results are necessarily atypical. We think that they're probably repeated in quite a large number of other states.

VICE CHAIR SUNDWALL: Jim, just to make sure I understand before you go on, these payments, though, are for hospital or long-term care facilities?

MR. TEISL: Yeah. So --

VICE CHAIR SUNDWALL: Not for doctors, not for other things. Just --

MR. TEISL: Supplemental payments or UPL payments, because they're made under the UPL, are typically additional lump sum payments made to institutional providers, hospitals, nursing facilities, intermediate care facilities. We do see some cases where states have developed state plan amendments to make supplemental payments to certain physician groups, and they've worked with CMS to sort of establish a benchmark. I think I'd have to look back to make sure I'm saying this right, but I think they use average commercial rates as the benchmark that they make those supplemental payments to.

Typically when we've seen those supplemental payments to physicians, they've been physicians owned by -- or physicians employed by state-owned and operated academic medical centers and things like that. The bulk of these payments go to hospitals. We see a number of cases where they also go to nursing facilities.

In the states where we were able to collect data, they didn't tend to make big supplemental payments to their nursing facilities. So for these couple slides, we've limited the data to the hospitals.

In the second slide here, we can see how a payment analysis such as a relatively common analysis to calculate payment to cost ratios could be affected by wether or not these supplemental payments are included. The message here is similar to the previous slide. Obviously, when you look at claims-based payments alone, in three of the states, the estimated payment to cost ratio is far less than if you were to include these non-DSH supplemental payments.

The only other thing that I would point out is that in those three states, we see a little bit of a shrinking of the degree of variation in cost coverage, and again, estimated cost coverage when we include these non-DSH supplemental payments. Again, we weren't trying to assess payment adequacy in these states, we're

not trying to draw conclusions about payment adequacy, but this demonstrates how these analyses could be affected depending on wether or not these payments are accounted for.

COMMISSIONER RILEY: Jim, before you go on, does this net out the taxes paid by hospitals?

MR. TEISL: So we did when we estimated costs using the total facility cost to charge ratio from the Medicare cost report. We then backed out provider taxes and other provider contributed non-Federal financing based on the assumption that they are not included as costs in providers' Medicare cost reports. And that was based on some language in the instructions, but this is one of those issues where we would probably want to do a little more research if we were to apply this more generally.

So based on the Commission's work to date, we offer up this option for a potential Commission recommendation, which would call for increased transparency into what the program is paying and to whom, and the types of analysis that could be informed by this information would include the type of things that all health care payers, frankly, are interested in, including knowing the extent to which payments might relate to costs and the role that payment plays in achieving program objectives, including access to necessary health care services and program efficiency. So you see it here. I won't read it.

To talk a little bit further about the rationale, again, these payments can be a large portion of total Medicaid payment. Existing Federal data sources don't generally include provider level supplemental payments, so aren't really sufficient for analysis of payment to these providers.

And perhaps collecting this data is a first step if we wish to further consider non-DSH supplemental payment policy, but also our ability to assess payment to these providers and, ultimately, the effects that those payments have on program objectives.

It's possible, for example, that the effect of payment policies intended to promote certain outcomes -- and as an example, I offer up, you know, using a DRG base methodology to encourage efficiency -- in the provision of hospital services, might end up being muted by the fact that these non-DSH supplemental payments are then paid in these lump sums periodically on top of those base payments.

But at the same time, it's possible that supplemental payments themselves promote increased access and allow the providers to serve the Medicaid population. Without knowing what providers receive them and what amounts, we can't start to draw those conclusions or really even try to.

I'll add, and this has come up in a couple of sessions previously, while we're talking about fee-for-service payments that are made in a fee-for-service construct, better understanding these payments and who they go to also helps inform discussion of their role in states' efforts to move towards increased use of Medicaid managed care.

We've talked before about how states have cited the use of these payments and the inability to make them under managed care as a barrier to their move in that direction. Again, knowing more about what those payments are and who they go to might help us inform that discussion a little bit more.

The collection of Medicaid payment data is already a requirement per the statute. CMS could, we believe, enforce the requirement to report these more routinely through MSIS. MSIS appears to have the capability to capture them. And it appears that the next iteration of MSIS, T-MSIS, Transformed-MSIS, will have the added capability to capture these data should the requirement to report them be emphasized by CMS, and should they work with states on sort of standard requirements for making sure that they're included.

Supplemental payment data are collected through other oversight activities, and we've mentioned

specifically DSH audits, though again, DSH audits are only for hospitals that receive DSH, and payment data are generally available something like three years after the point at which they're actually made.

They're also now collected as part of the requirements for states to demonstrate their compliance with the upper payment limits each year, but here again, we don't see any sort of avenue for that payment data being readily available outside of assessment of UPL compliance at the regional offices through spread sheets.

So again, while improved data collection availability may be a reasonable first step, we also recognize that policy-makers have to remain sensitive, both to the administrative effort required for states to provide these data and for the Federal Government to collect it and to make it available, while at the same time keeping an eye towards preserving the flexibility that the Medicaid statute has afforded to states.

When we looked at the impact, I heard some comments this morning about being in CBO's lowest bucket, but there's one even lower, which is no change in Federal spending, and that was their assessment of this potential recommendation. That said, we acknowledge that there could be some administrative effort required to develop reporting standards, particularly at the Federal level, and then making the data available.

States make these payments to providers in accordance with their approved state plan. They make the payments to enrolled providers. Presumably they know how much they pay those providers. Thus, we don't think it would be a huge lift for states to provide that data in some sort of a standardized format. We don't see any direct effect on payments or services, particularly in the short term, though over time, you know, we recognize that sort of increased, you know, scrutiny could lead to modifications in state payment methodologies.

So in closing, I just want to acknowledge that knowing what payments are in the Medicaid program

and who the payments go to is clearly a big piece and a big part of our ability to fulfill our responsibility. But that said, it is only one piece and we continue to have challenges that we're going to have to deal with as we continue down this road of assessing Medicaid payment.

Some of those might include consistent and reliable approaches to estimating costs across hospitals and other providers in the Medicaid program, as well as better understanding the range of state payment policies and the incentives that states are trying to create through the use of those policies, both in their base rate methods and then, you know, expanded movement towards things like shared savings approaches or bundled payments. We need to know what states are doing in order to sort of accurately assess the payments that providers are getting.

CHAIR ROWLAND: Comments? David.

VICE CHAIR SUNDWALL: Well, thank you, Jim. This is an issue that I've found one of the most striking things I've learned since I've been on the Commission. I had no idea of the scope and the amount of this. Now, just to remind me or refresh my memory, this is only one component of supplemental payments. They also do inter-governmental transfers and bed taxes.

MR. TEISL: Now, things like inter-government transfers and health care-related taxes and certified public expenditures are different ways that states raise the non-Federal share of their Medicaid spending, just as they use general revenue or, you know, general sales taxes or whatever other ways that states --

VICE CHAIR SUNDWALL: So the supplemental payment is just another -- maybe I put it under the wrong umbrella, but it's another -- under the category of how do you increase your Federal match.

MR. TEISL: In this case, we're really talking about different ways that states pay providers and the

extent to which they make payments in lump sums that are separate from what they might do --

VICE CHAIR SUNDWALL: So this has nothing to do with the Federal match. This is just another way of getting an enhanced payment.

MR. TEISL: What we're talking about today is specifically these payments, right.

VICE CHAIR SUNDWALL: Thank you.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: I have a number of comments. The first one really is not about this chapter, but is a critical part, I think, of supplemental payment and maybe really goes with Veronica's discussion, and that is about the DSH payment.

Since we're an access Commission and since the safety net is such a critical part of access for Medicaid, especially, as well as CHIP patients, and since DSH is such a critical part of the survival of the safety net, I mean, the data that was published when NAPH was NAPH, what would be the margin of all the safety net hospitals if you took the DSH payment out and they were all negative?

I think we need to, as a Commission, make some statement about continuation of DSH payments until we know what's going to happen with enrollment, because the current cuts in DSH were predicated on the fact that all of these new people would come into either the Medicaid expansion, which now won't happen in a number of the states, weren't covered under the subsidized premiums so there would be less uninsured so DSH could be cut.

We have no way of knowing that and this will be so destabilizing, particularly in those safety nets where Medicaid is not expanded. I don't think they could survive. And since access is a critical part of our

charge, I don't see how we could not make some recommendation about that. So that's my first comment, which is not about this supplemental payment, but the broader supplemental payment.

My other question about this, first of all, thank you for continuing to enter this terrain which is like a tar pit. But I do have a couple of questions. The fact that one of four or five states couldn't respond, does that really make you think that it's not going to be so easy to get the data without revealing, I mean, anything about the states? Do you want to answer these one at a time?

MR. TEISL: It's up to you, whatever you prefer.

CHAIR ROWLAND: Let's take them one at a time.

MR. TEISL: Yeah. I don't think so. I think that ultimately, participation in this analysis was voluntary and, you know, while at least this one state sort of went through the preliminary work with us and went through the interviews, ultimately they just -- they didn't feel like they could put the time into producing the data in the time frame that we needed it.

I would be hesitant to sort of say that means they can't do it, you know, recognizing that there might be some effort if inclusion of these data became a point of emphasis. Certainly it would take some work to sort of create the systems to include it in their reporting, you know, through emphasis, for example. But going forward, I wouldn't expect that to be a big deal.

COMMISSIONER GABOW: My second question is, the things that you list on Page 11 of the report about the data limitations, the three key bullets there seem rather important. So how much of an issue do you think those are, maybe not directionally in what you found, but in magnitude of what you found?

MR. TEISL: Well, it actually gives me the opportunity to say again that we weren't actually trying to

assess the payment that these states were making. We were trying to get a better sense of the degree of magnitude of these supplemental payments or that these supplemental payments make towards total Medicaid payment.

So for the purposes of the work we did, we sort of -- we raised those limitations in order to say, Look, don't take at face value that we were saying these are nationally-representative reflections of the degree of cost coverage for hospitals. What we are saying is that including supplemental payments or not might double the amount of cost coverage that you see.

So again, you know, if going forward we had these data available, we would have to sort of refocus, I think, on those limitations to make sure that the conclusions we draw from the payment data we have are reliable.

COMMISSIONER GABOW: Another issue is the degree to which the states use UPL varies in terms of the percentage of their available UPL they draw down. So it does have an impact on the effective Federal match, I think. So I'm all in favor of transparency and I know the Commission is, but if we're going to be transparent at the provider level, I believe we need to be transparent at the state level, also, and really present data about the range of draw-down of available UPL and what this does to affect a state match.

Because I think it underscores the point that we should probably make at the beginning of this chapter, and you do to a degree, but I would say maybe stronger, that while this is a state/Federal program, the states don't have the wherewithal to pay for what has to be done, and therefore, we've created these incredible work-arounds to what our goal in simplification should be to be a very straight-forward payment mechanism to cover what really has to be covered for adequate payment that therefore you would know and you would

know what you're getting for your dollar.

And because we've created these incredibly complex systems, we don't know that. So I think we have to say that at the beginning, that these are around creating adequate payment levels and enabling the states to deliver what they're supposed to deliver where we should in the end do this is a much more straight-forward way. But I think we have to be transparent about the state issues as well as the individual providers.

And then regarding the recommendation, I'm fine with it, but I would suggest we add that it be standardized collection and analyzable data. To collect it in a non-standard way that's not analyzable just adds a burden for no reason and is wasteful. Thanks, Jim.

CHAIR ROWLAND: Mark and then Sara.

COMMISSIONER HOYT: I had two primary comments, but start by saying my thanks to you for wrestling with such a difficult topic. My two comments were, I felt like the managed care issues were largely ignored or set aside, and if it's the case that a state like Texas wants to go into, just as an example since Billy was here, wanted to do managed care contracting, then they've got this huge roadblock, too. Now, what happens with the supplemental payments? It feels like managed care contracting has been around for decades. If the non-DSH supplemental payment policy has never been rewritten or amended to reflect, quote, the real world or modernized, it should be.

Even if we don't know exactly what that should look like yet, it just seems obvious to me that if you have this total void here, and it's getting a little bit worse, so to speak, every year, more managed care days, Medicaid managed care days being ignored or kind of not dealt with, then we should raise that and not just walk past it.

My other comment that I gave you already on the recommendation was, I'd be in favor of going a little broader and going after the provider taxes as well. I know that maybe opens another can of worms of what are states doing with that money, but there, if we're focused primarily on payment to providers, well, I'm sure they all know exactly what they paid back to the state and the taxes. It should be easier to collect.

And we've only half-solved the mystery if we just collect the supplemental payments or get that at the provider level, but we don't have the tax and we still don't know the net payment. I think that's pretty valuable and the providers, I would think, could, you know, a hospital or a nursing home could care less what the state did with the money. It's just lost revenue to them. So I'd still be in favor of chasing it.

CHAIR ROWLAND: I think to Patty's earlier comment about the DSH-related things and to your comment about provider taxes, these are clearly areas that this chapter could identify as areas we need to pursue in the future but are not prepared to address at least at this point in the March report. Sara.

COMMISSIONER ROSENBAUM: I like, I'm sure everyone of us around the table, you are -- my hat is off to you because this is, you know, the tenth of circle of hell for Medicaid. Where the money comes from and where it goes, and you deserve, I think, a medal of honor for just being our person who is constantly trying to unravel these questions.

I remember early on in MACPAC we had a discussion about the very beginnings of the program and the fact that the program was established without really thinking clearly about the financial base on which the program was resting and nobody really thought a lot because at that point, a program like Medicaid was not an entitlement. The Supreme Court hadn't declared that yet and we didn't have the kind of health care cost problem we have today, and I don't think anybody knew, you know, ultimately could dream of how much the

private insurance system would degrade and would fall apart and Medicaid would grow.

And so, now we have this incredibly difficult situation on our hands. And I think -- I just want to -- I mean, I want to add my voice on the question of how we frame this discussion, and I realize that so many decades have gone by now of framing the discussion. I don't exactly know how we dig ourselves out of the box.

So, for example, we say these are lump sum payments not tied to patient care. You know, another way of looking at these payments is that a state Medicaid program, rightfully, may set its Medicaid payment levels at a very deeply discounted rate, far, far below what a commercial payer, even Medicare, sets its rates at.

But then for certain hospitals, essentially, it lessens -- it mitigates the discount on the payment rate for the services, because there are certain hospitals in the state that can absorb really deep discounts and there are certain hospitals that can't. And that manifests itself in the form of a year-end payment that's a mitigating payment, you find, or periodic, however it's done.

That's a very different way of expressing to Congress what's going on here from saying, lump sum money is exchanging hands, sort of by implication, as the quid pro quo for your provider taxes or your inter-government transfers, and the money is not related to anything. The money is, I think, probably distinctly related to something, and that is the extent of particular hospitals' obligations to the program.

And I don't know because I know that your job here was to really study sort of the financial flow, but if we dug further, I think we would understand which hospitals are showing these transfer arrangements. And I'd also like to know more, and, I mean, we've talked about it, Donna and I have talked about it, I've talked about it with Trish.

Why a state wants to be able to set a deeply discounted rate and then mitigate it for certain hospitals. And I assumed that this is -- look, every Medicare payment reform we're talking about is the same thing. It's down-side risk. You set a deeply discounted rate and then you mitigate it for certain providers that perform well.

And so, what I'd like to see is that we not get sucked into 25 years of talking about this as if it's just a trend, you know, sort of a shady transaction unrelated to deep thinking on the part of state Medicaid programs and providers about what to do with the fact that they've got these huge responsibilities and really a formula, a financing formula that's not a friendly formula.

COMMISSIONER RILEY: I think Sara always make great points, but I also think when you think about the movement to accountable care organizations, it will often be hospital-based. We need to know this level of detail before we start to capitate entities that are, at best, not capable of real risk sharing.

COMMISSIONER ROSENBAUM: Well, and I mean, I think all this is without in any way -- I don't in any way disagree with the notion that we need more information about payments. I absolutely agree with Patty, that really, this is a case where we want to understand a lot more about how payment rates are set, and within the bigger picture of how payment rates are set, why we use -- why state Medicaid programs make choices about certain income transfer strategies within that, because that's all this is, is an income transfer strategy.

We have to know these things for quality. We need to know who can manage risk. You know, we need this information, and the fact that CMS has information and basically no one has access to it is not good either.

CHAIR ROWLAND: Herman.

COMMISSIONER GRAY: As one who is responsible for running a safety net children's hospital, I couldn't agree with Sara more, though. I think the language is important and the sort of inferences that are contained in that language.

A couple of questions that I have have been touched on, but I don't know that there's an answer but I'd like to ask anyway.

Do we have any sense of how these dollars are distributed to rural hospitals or safety net hospitals? Do we have any sense maybe in the three hospitals that gave us data how those dollars are actually distributed proportionally compared to more mainstream hospitals, as an example?

MR. TEISL: In these four states, I'd have to look back and get back to you on our ability to sort of look. I think we tried to look at some public versus private. I'm not sure we looked at rural versus urban or MSA.

I will say that in order for -- I mean, these payment methodologies have to be approved by CMS as part of state Medicaid plans. And in order to be approvable, they have to demonstrate a relationship to the provision of Medicaid services. So a lot of what we see is the payments will be distributed based on the proportion of Medicaid days that providers provide. In some states we see sort of a lump sum per Medicaid discharge.

In certain cases, the payments are limited to, for example, non-state government owned and operated hospitals, by which I mean county or municipality owned and operated hospitals. As with everything that we talk about, there's a spectrum of the way that these things are done, but it is important to sort of remember

that they do have to be approved by CMS, and thus related to Medicaid utilization.

COMMISSIONER GRAY: Thank you.

The second question, which I'll be quite confident you can't answer but I'll ask it anyway, is if CMS has presumably/authority to get this data currently through MSIS, why haven't they asked for it?

MR. TEISL: It hasn't been a point of emphasis to date, and that's the best explanation I can give.

CHAIR ROWLAND: So CMS approves the plans, but it doesn't collect the data on what happens?

MR. TEISL: So CMS doesn't collect any -- doesn't really collect any provider level payment data for the purposes of determining Federal match. I mean, CMS-64 is the aggregate service level reporting.

The statute does require states to report their payment data through the Medicaid Statistical Information System. That system is capable of also receiving these supplemental payments. We don't think it's being done.

We're doing some work to try to see --

CHAIR ROWLAND: But is our recommendation basically asking that it be an identifiable part of that dataset? Or are we asking for some separate reporting?

MR. TEISL: The way the recommendation is worded now is simply that the Secretary collect these data and make them available. The description of the potential mechanisms, at this point, is in the rationale. It would be up for discussion if we wanted to be clear that we think it should be part of MSIS.

CHAIR ROWLAND: I have Trish, Andy, and Donna.

COMMISSIONER RILEY: I guess before we vote on this recommendation, it does seem -- given that they're already collecting data -- it seems a little mushy. I wonder if we could add to it what questions

we'd like to see the data answer so that we're a bit more specific about why we want this data and what issues we're trying to address.

COMMISSIONER COHEN: I just wanted a clarification on something I think you said earlier, Jim.

I think our focus here is properly on payment and certainly I agree with Mark that if you look at payment to facilities only and don't take into account what other sort of costs associated with that payment there might be that you're not -- sort of, your data could be misleading. But I understood you to say that using information already on a cost report, you could net that out.

And it's also my understanding, or I guess maybe I'm stating a preference here -- I mean, again, I think our proper focus here is on payment and how payment relates to the things that we care about, quality and access and the other things that we're charged with doing in the Medicaid program, not charged I think with sort of policing a financial relationship between the states and the Federal Government. Or at least that's not the area that I think we are first focused on.

So I guess I just want to say with existing data that we have access to, plus the data that we'd be asking for in terms of payment directly to facility by facility payment, can we get a more accurate understanding of what those sort of net payments really are?

I think you had said previously yes but I just wanted to make sure I understood that.

MR. TEISL: When you say net payment, you mean net of...

COMMISSIONER COHEN: Yes.

MR. TEISL: Net of financing contributing at the provider level? I'm not sure that we could do that right now, not with other data sources that we have. We would need to know what each provider contributes

in health care related taxes or IGTs or anything else.

COMMISSIONER COHEN: In the cost to charge ratio stuff that you did? I must have misunderstood.

MR. TEISL: We asked the states for the provider specific financing data and added those to the costs that we were able to determine from the cost report.

COMMISSIONER COHEN: Thanks.

CHAIR ROWLAND: Donna.

COMMISSIONER CHECKETT: Jim, help me understand in like a really literal way what will be different if the Secretary does this? We're going to be able to -- we, being MACPAC and policy people in Washington, and whomever else is interested -- is going to be able to drill down and say at St. Mary's Hospital they provided this amount of services for this amount of money?

Just help me understand what we're going to really get out of this.

MR. TEISL: I don't -- I think I'd be mistaken if I gave you the impression that this would be some sort of a light switch moment, obviously. I mean, it would take time for standardization of reporting to work out. We still have issues with -- a lot of the things I know April has talked about in the past with respect to billing IDs and the time periods and to -- for example, if we wanted to start to do the sort of things that other payers do, like consider payer specific margins in the Medicaid program, this is a step towards our ability to do that. I wouldn't be completely honest if I said we could do it as soon as you make the total payment available.

I think the case we're trying to make here is without the total payment, we don't have a chance.

COMMISSIONER CHECKETT: Thank you.

CHAIR ROWLAND: Trish and then Patty.

COMMISSIONER RILEY: You can tell this is my favorite paper, among equally excellent papers.

I'm still where Andy is, I think, because I think what would be valuable, I think, to policymakers would be a comparable understanding of cost-to-payment ratios across states by hospitals, by provider. But the cost would have to include the cost of the taxes contributed.

So it seems to me that if you're really going to have a comparable, that you'd have to be able to include the cost of the taxes or net them out somehow to make this useful information. Because then you've got useful information about how adequate are the payments to hospitals? And how much do these supplemental payments effectively change that ratio?

And I think that would be a very useful policy. In fact, I think this is really some of the best drill down we've done. But I think if we can't connect it to the cost of the taxes, then if we do come up with results it just invites hospitals to say -- you know, we'll have a dueling data issue. The hospitals will say this data is not correct because it doesn't show all the tax we pay in.

COMMISSIONER GABOW: I think this is fine, as a start, and you put the caveat this is a building block towards being able to get there. You know, life wasn't invented in a day, and this is such a --

UNIDENTIFIED SPEAKER: [off microphone.] It took seven.

COMMISSIONER GABOW: Yes, seven, at least, if not 10 billion years.

But anyway, this is a complex issue and I think we say we're starting to peel the onion to be able to get to adequacy of payment and how that relates to quality of care.

But what I was going to come back to was I intend to perseverate on the DSH, on a comment about

the extension of DSH.

I think it's fine to say we're going to put it off, but this is going to happen in 2014. And so if we don't comment on it now, we will be comment on it after the horse is out of the barn.

So I just want to have my final perseveration that I think for this Commission not to weigh in on something as central as that that affects access would be a mistake.

I will not perseverate further.

CHAIR ROWLAND: Patty, we hear you, and clearly we will try in January to put a discussion of the DSH issue onto the agenda because you're right, it is an issue that will take effect in 2014 and it has very different implications depending on where states have decided to go with their expansion.

But now back to Donna on this topic.

COMMISSIONER CHECKETT: Poor Jim, he gets the one thing that we all get so worked -- well, we get worked up about a lot. But really, it is a fascinating topic.

And it occurs to me, as I look back through this, those tricky states, they actually do UPL draws on lots of different providers, although hospitals I think are the big dollars. But it's the state facilities and it's nursing homes and county nursing homes and state nursing homes and on and on and on.

So I assume that you're meaning to apply this recommendation to all provider types?

MR. TEISL: Yes.

COMMISSIONER CHECKETT: Yes, indeed.

So do you know the breakdown, by any chance? How much of it goes to providers that states are drawing on hospitals as opposed to other facilities?

MR. TEISL: I can't remember, though I would refer you to Table 20 in our March report. And we can look at it as well. The vast majority go to hospitals.

COMMISSIONER CHECKETT: It's hospitals, yes.

Thank you.

CHAIR ROWLAND: Other comments?

[No response.]

CHAIR ROWLAND: All right. Well, Jim, as usual you have provided us with a lot of food for thought and we've given you a lot of comments back.

Thank you and we'll continue to look at this.

I thought the comment about how would this recommendation be used is a good one to add to the rationale. What is the purpose of our recommendation, really?

Now we're going to turn to access measures for March and MACStats. And Anna Sommers will join us.

We are now at Tab 8 of your briefing books.

Session 7:

Access Measures for March MACStats

* MS. SOMMERS: Thank you. The goal of this session is to present to you a new section of MACStats that covers measures of access to care for individuals covered in Medicaid. I will first provide a bit of background on why we're developing this new section. Then I'll go through the data sources from which the measures are drawn. Our approach to measurement briefly. The tables and how they're organized.

And finally, I'll present some examples in the tables so you'll get a sense for how to read the tables and give you a sense for how this section of MACStats will add value to the information currently available on access to care in Medicaid.

As you know, part of MACPAC's charge is to monitor access to care for individuals covered by Medicaid. The Commission has conducted a variety of activities to meet this charge, including data analyses on access to care for non-elderly adults and children, literature reviews, and presentations from researchers and state Medicaid directors and other state officials on a range of access topics.

The MACStats tables produced in every report to Congress function as a central location of the most updated information about many aspects of the Medicaid program. But tables currently include only a few access measures. So to address this gap, we're proposing to add five tables of access measures.

All measures will be drawn from the most recently available data in five Federal surveys. These five surveys were chosen for at least one of two reasons. Either they're the sole source of information about access and quality for a population or a particular measure, or their survey data, if there was one more than one source, is released in the most timely manner.

The surveys are described in Tab 8 in your background paper, and if you have any questions about the surveys, I'll be happy to answer them. We selected a total of 53 measures. They're organized into five domains of access that are commonly recognized by experts, and also reflect MACPAC's own access framework.

The number of measures to be produced in each domain is shown in parentheses. There are four measures of provider availability drawn from physician surveys that would affect access to care for Medicaid

beneficiaries. There are 12 measures in the domain connection to the health care system, which are things like whether they have a usual source of care or had trouble finding a doctor. And specific to children with health care needs, whether they have adequate care coordination, as an example.

There are nine measures under our contact with health professionals, including contact with primary care doctors, mid-level clinicians, dental, and mental health professionals. There are 11 measures under timeliness of care, such as experiences of delayed care and unmet need to care and other problems which result in delays such as problems obtaining referrals.

There are 17 measures under receipt of appropriate care. Mainly this covers receipt of preventive services and recommended screenings. It also includes two measures related to emergency room use. The measures are distributed across four populations. There are 19 measures for children. There are a smaller set of measures for children with special health care needs.

There are 22 measures for adults under the age of 65. And then there are, again, a smaller subset of measures for adult Medicaid enrollees receiving Supplemental Security Income, SSI, and their counterparts in Medicaid.

So across the next two slides are the list of tables that you have in your packet and I'd direct you to Tab 8 to take a look at them. The first table presents measures from physician surveys of participation in Medicaid. Table 23 also provides some practice features for our national sample of office-based physicians. We show these measures for measures for all primary care physicians, general pediatrics, and other primary care physicians.

Table 24 covers non-institutionalized children by source of health insurance. The table presents each

measure for all children, children covered by Medicaid, by private insurance, and who are uninsured. These measures are drawn from the 2012 National Health Interview Survey and the 2011/2012 National Survey of Children's Health.

Table 25 shows again a smaller set of measures for children with special health care needs by source of health insurance. The table compares children with special health care needs covered by Medicaid, CHIP, private insurance, or uninsured at the time of the interview. These measures are drawn from the National Survey of Children's Health and also from the National Survey of Children with Special Health Care Needs.

Table 26 present data for non-institutionalized adults ages 19 to 64 by source of insurance. Each measure is displayed for all adults, adults covered by Medicaid, by private insurance, and who are uninsured. All these measures are drawn from the 2012 National Health Interview Survey.

Table 27 presents a smaller set of measures for adults enrolled in Medicaid comparing those receiving SSI to other adult Medicaid enrollees. Receipt of SSI is serving as a proxy for a sample of individuals with disabilities. This definition does not capture all persons with disabilities, but for now, this is an approach that provides the most uniform definition over survey years to track the experience of adults with a diverse set of complex needs.

And then in addition, we'll provide a reference guide, which is currently labeled 28, Table 28, that provides a detailed description of each measure, the populations to be measured, data sources, and also a brief rationale for the measures selection. This table may be published as an appendix in the March report or may become available as an online resource.

The tables report only national estimates. This will complement the many activities states are already

undertaking to report access in their own programs, and it also simply reflects the practical reality that there are very few measures of access available at the state level and for all 50 states.

So next I'm going to show you three examples of the measures that you'll find in your tables. This one is one of the measures under the domain contact with health professionals. It's labeled C-7a in Table 26. And this one shows the percentages of individuals who say they saw a nurse practitioner, physician assistant, or midwife in the past 12 months.

The asterisk on the far right there indicates where the percentage is significantly different from Medicaid enrollees. So the table shows here there's no difference in the proportion of persons who saw a mid-level clinician between adults covered by Medicaid or private insurance.

About one-fifth of both groups report that they saw a mid-level clinician, while the percentage for the uninsured in the far right column, who saw one of these clinicians is lower at 9 percent. So that's a statistically significant difference.

And I also want to mention that we know from physician data in Table 23 that about half of primary care physicians worked with a mid-level clinician in 2012, and these clinicians can help to expand access for Medicaid patients even if the total number of physicians seeing Medicaid patients does not increase.

So as more practices bring on these clinicians, as we expect to happen, we could expect the percentage of adults who have seen a mid-level clinician to increase.

The next example is under the domain timeliness of care. This is the percentage of Medicaid adults who reported a delay in care for a reason related to an access barrier. It's labeled Measure T-8. In Table 27, this measure appears for SSI enrollees compared to other adult Medicaid enrollees.

And here we see that the percentage reporting delayed medical care for a reason related to access is significantly higher for SSI enrollees by about 7 percentage points. It's in the top row. And we group the reasons for delayed care into three rows below, delays due to cost; transportation, didn't have transportation; or provider-related barriers. And these provider-related barriers we define as including the responses, couldn't get an appointment, have to wait too long to see a doctor, couldn't go when open, and couldn't get through on the phone.

These are all reasons that reflect a provider's accessibility to its patients. When we compare these two populations based on the reasons for the delays, we see that the same percentage of both populations reported delays due to cost, about 7 or 8 percent. There's no difference there. And also the same percentage for provider-related barriers, about 15 percent.

The difference is in the percentage of persons reported they didn't have transportation to get to the provider. Almost three times as many SSI adults reported this barrier. So this is an example of a measure that will help better gauge the scope and source of barriers to care as reported by Medicaid enrollees.

And then finally, this last example is from the domain receipt of appropriate care. This measure can be found on Table 24. It's labeled A-3 and it shows the percentage of children whose parents reported the child had at least one preventive medical visit in the past 12 months. This is from the National Survey of Children's Health and columns compare children covered by Medicaid or CHIP to children covered by private insurance only at the time of interview.

As in this measure, in some cases, we will present separate estimates for different age ranges, separately for people with chronic conditions, or individuals with elevated health risks.

So for this measure, in the first row, it shows us that there's no difference between Medicaid and CHIP and privately-insured children in this overall percentage. But when we show the same measure for the three age ranges, we learn a couple of things. One is that the youngest age group is more likely to have a visit than the older age groups.

And we also find that younger children covered by private insurance are more likely to have received a preventive visit than Medicaid or CHIP children by about 4 percentage points, while children in other age groups do appear to be comparable.

COMMISSIONER ROSENBAUM: And why are we not showing the uninsured?

MS. SOMMERS: They are in the table. Just for illustrative purposes for this slide, I didn't show them.

CHAIR ROWLAND: And the privately insured are of all incomes?

MS. SOMMERS: Yes.

CHAIR ROWLAND: So that they include -- it's not a comparison by income. It's a comparison by insurance stats.

MS. SOMMERS: That's correct. So that is one of the caveats that I want to make clear when you're looking at these tables and interpreting the measures. So first of all, the measures are drawn from various surveys and even different survey years from the same survey. So you should not compare measures from different surveys.

The second caveat is that statistics are not adjusted for differences in age, race, ethnicity, income, health, family characteristics, regional variation. These are all things that prior analysis demonstrates. Such

differences can explain many, but not all differences in access to care between Medicaid and private-insured individuals.

These tables are not intended to provide analysis on this topic; rather, they're intended to be a source of information about the scope and levels of access experienced in the Medicaid program, and in turn, can serve as a starting point for policy questions and future research.

The third caveat is that all of these measures are based on respondents to surveys, and when people report about their own service use, they may not recall accurately. However, that's true across the board for people in all insurance categories and incomes. So relative differences between populations, and over time are reliable.

I also want to mention that we're in the process of working with the National Center for Health Statistics staff on validating and finalizing some of the measures drawn from the physician data in Table 23. So you can expect that there will be some changes to that table. So that concludes my presentation and we now look forward to hearing your reaction to this new section of MACStats.

CHAIR ROWLAND: Okay. Patty, start.

COMMISSIONER GABOW: Did I understand you correctly that all of the data on all of the tables are self-reported data? None of this is verifiable, quantitative data?

MS. SOMMERS: That's right. That includes the physician data, which are mostly paper mail surveys to physicians who filled them out. So even that data is self-reported by physicians.

COMMISSIONER GABOW: So I think that emphasizing that is really important because it could be very different if we actually had immunization data, for example, on preventive visits.

CHAIR ROWLAND: This is individuals reporting that their child had an immunization as opposed to the Public Health Department giving you that data. Other comments? Trish and then Denise.

COMMISSIONER RILEY: I appreciated the breakdown between SSI and non-SSI, but I think it is kind of striking in all this work and we ought to mention it in the narrative someplace, not in MACStats, the dearth of information about people's disabilities, and given that that's a Medicaid-only expenditure as we know, it's really kind of sad that we have so few measures, yet we spend so much and know so little.

CHAIR ROWLAND: And on that point, I think explaining in MACStats or wherever the difference between who you're counting when you're looking at SSI and who you're including when you just look at other adults between 19 and 64, you would expect some of those differences to be as great as they are because of who -- I mean, the disabled would have greater difficulty with transportation than someone who could take a bus. Okay. Denise and then Burt.

COMMISSIONER HENNING: I guess a couple of points. One would be when you're relying on self-reported data. I know all the time my patients -- it doesn't matter how many times I tell them I'm a nurse-midwife or a midwife or whatever, they'll answer the phone. They'll say, Just a minute. The doctor is here.

And so, I have a feeling that a lot of these might be under-reported as far as, you know, access, people that have actually seen a nurse practitioner versus a physician. So that's one point.

And then the other point is, if you're expecting to make any kind of decisions based on someone mailing back a survey, especially when you have someone that has access to care problems, those are the exact people that will never that survey back because they've already moved from the last time that they were seen by

anybody. So I think that that needs to be taken into account, too.

MS. SOMMERS: Oh, let me just clarify. The paper surveys I was referring to were for the physicians. The patients, the beneficiaries in the Federal surveys of citizens and non-citizens that reside in the U.S. are all CATI, so they're computer-assisted, telephone or in person surveys done in their home.

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: I just want to thank you for working on this because at this time with the implementation of the ACA, it seems to me like the focus of attention is going to be on expansion, expansion, more people covered. And so, during this time, I think it's going to be really interesting to see, in fact, what barriers to access to care remain in spite of expanded coverage. So we need to keep our statutory responsibility to monitor this access. So this data will be helpful, and I think particularly timely.

CHAIR ROWLAND: Well, I certainly appreciate the measures that are here and the exhaustive look at what surveys provide what information. I think that that's a very helpful step for us to know where can you go to look for some of these statistics and then what are the limitations of them.

But I also think that it's important not just in monitoring the Affordable Care Act and its implementation, but in answering some of the questions that we have heard about Medicaid's role and whether Medicaid actually does provide reasonable access to care, how that does compare to care for those with private insurance.

And really, I think, this is a great start for digging deeper at really the overall performance of the different methods of insurance coverage for the population, and a great baseline against which we can look at what some of the changes are going forward. So Burt had a comment and I was cutting him off, so now I'll

go back to Burt before I excuse Anna.

COMMISSIONER EDELSTEIN: Actually I have a question for Anna. What are your thoughts about taking a look at the MEPS data source? Because when you compare NHANES, NHIS, and MEPS, all of which are some form of self-reporting, the MEPS is the most stringent and generally reports the lowest rates.

MS. SOMMERS: Yeah. So with respect to the Medical Expenditure Panel Survey, because it's a longitudinal and panel design, the lag to the data release is much longer. So it's a full maybe year-and-a-half longer than NHIS. So we get 2012 data from the NHIS by August of 2013. We look at the 2013 data by August of 2014. And the MEPS data is much longer.

There's a lot of overlap now in what they ask because National Health Interview Survey has broadly expanded the number of questions they have on access to care. So it's become a much better source, at least for adults. I will say for children, there's still little attention to what is specifically of interest to children's health and health care.

But I want to say that this is just for the purposes of tracking on an ongoing basis, on an annual basis, whether we're seeing changes or differences over time, we can and expect to do other analyses where we can compare what's being reported across surveys, for example, to point those things out, that yeah, there are differences in the level that's reported by survey.

CHAIR ROWLAND: Thank you, Anna.

And now, since we're right on time, we will turn to Medicaid managed care and Moira will join us again. I would vote for putting some of the longer tables in the description, the data at least, as an appendix

in the full report, because I think it really does speak to how we're trying to assess access and what some of the areas are. So I think it's great to have in MACStats, but I think this is really a very important step forward in looking at access measures.

Session 8:

Examining Medicaid Managed Care

* MS. FORBES: Thank you. So, this session will be a little change of pace. This has nothing to do with the March report. You don't have to make any decisions. I'm just going to give you an update on what we're working on right now with Medicaid managed care and how it relates to some of the other things that MACPAC is interested in.

CHAIR ROWLAND: They'll have to pay attention.

MS. FORBES: Yes. It's the wrong time of day for that.

So MACPAC last took a deep look at managed care in its June 2011 report to the Congress. We've provided updates in MACStats since then, but it's been a while since there was a deep look at this. Of course, managed care has continued to grow and, you know, more states have mandated that beneficiaries enroll in managed care. They've expanded to include additional geographic areas, they've added more complicated populations, they've converted primary care case management programs to full risk. There's been a lot of growth in managed care since 2011.

In addition, a lot of the states that are implementing the Medicaid expansion in 2014 will be moving a lot of those beneficiaries -- I've heard estimates as high as 90 percent of the expansion group will be moving into managed care.

So because managed care encompasses both delivery and payment issues, which are high priority areas for Commission work, as you'll recall, you know, this came up. This was raised as an issue of importance at the last July's retreat with specific interest in better understanding how managed care delivery systems are serving enrollees, how we measure performance, and the relationship between innovations and payment policy, which are all very important issues.

So our work in the coming year will focus on reviewing the current mechanisms used by the states and CMS to oversee the programmatic and financial aspects of comprehensive risk-based managed care programs. We're going to be looking to identify gaps and inefficiencies in oversight and payment processes or policies, and look for additional tools, strategies, and opportunities to strengthen Medicaid managed care.

So just to provide a little background, over the past 20 years or so, Medicaid has evolved from an almost entirely fee-for-service program to one in which managed care plays a dominant role. We looked at the last Kaiser survey, the 2013 survey of Medicaid directors. It said that 39 states expected to expand or make significant changes in their managed care programs in 2013 and 2014, which, as I said, includes expanding geographically, expanding new populations, shifting from voluntary to mandatory managed care enrollment, and implementing new quality and payment rules.

A couple of states, Louisiana, Kentucky, New Hampshire in particular, are states that have had -- maybe have tried to do managed care in the past, but have never really gotten off the ground are really making a big push towards, you know, going whole hog for managed care.

Some of the large states, California, Florida, and Texas, have implemented some very significant expansions. So the proportion of Medicaid beneficiaries who will be enrolled in managed care, you know, by

the end of the next year is going to be much larger.

So over the coming year, we plan to focus, as I said, on oversight and tools to measure effectiveness and value in managed care delivery systems. There are three specific activities underway and we'll begin reporting on the results of these in the next couple of months. The areas are program oversight, payment mechanisms, and data for understanding Medicaid managed care, and I'll give you a little more detail on each of these.

So for program oversight, near and dear to my heart, Federal and state governments have an obligation to know whether they are paying for appropriate quality care and whether enrollees have adequate access to necessary and contractually obligated services. While states contract with MCOs to provide for and ensure access to the clients of the services, the state still has an obligation to make sure that enrollees are, in fact, getting those services.

At the Federal level, CMS has the responsibility to make sure that the states are overseeing the MCOs and that the Federal Government is receiving value for the money it's putting in. There's not a lot of information available on how this is done or what the results are. We have some knowledge about what states put in their contracts. We may see some state reporting. In the requirements, we may see some state reports that come out of that.

But how CMS and states use the collected information is not clear, which makes it hard for us to ascertain whether the existing oversight strategies are sufficient and whether they are, you know, detecting problems that may impact access and quality for beneficiaries.

So to gather more information on the Medicaid managed care oversight process is the first step. We

recently let a contract to NORC. They are going to review applicable state and Federal laws, the regulations, whatever documents they can rustle up. They're going to conduct interviews with Federal Government officials, including both central and regional offices.

They're going to interview state staff and MCO staff in six states around the country. The study should help identify opportunities for improving oversight, monitoring, and enforcement. Ideally, we'll also find ways to help reduce administrative burden for CMS, states, and the MCOs so we can really be doing appropriate oversight and using our resources wisely.

This contract has just kicked off this month. We'll probably be reporting to you on the results of it in the late spring, like at the May or June meeting.

VICE CHAIR SUNDWALL: Who's doing it?

MS. FORBES: NORC. While that's going on, we're also interested in payment mechanisms for Medicaid managed care. So again, there are Federal rules around this. There are general Federal rules around payment. You know, Medicaid payments have to be consistent with efficiency, economy, and quality. We have to avoid payment for unnecessary utilization. Payments need to be sufficient to enlist providers.

There are also Federal rules specifically around managed care payments, capitation payments. They need to be actuarially sound and developed in accordance with generally accepted actuarial principles and practices. So doing this, setting payments for Medicaid managed care that are actuarially sound and don't overpay or underpay is a challenging business.

We have done some foundational work to describe the basic mechanics of capitation rate-setting. That was included in the June 2011 and June 2013 reports to the Congress. But we're going to do some

additional work to examine how states in practice are, you know, determining capitation rates and how CMS monitors and oversees the rate-setting process.

So we recently released a solicitation to procure support. We're going to convene an expert panel. We think we'll try and get 10 to 15 experts, including Federal and state Medicaid representatives, actuaries, MCO representatives who are involved in all aspects of the rate-setting process.

And some of the topics we want to cover at the roundtable will include the application of the actuarial soundness rules, risk adjustment methodologies, how they're using quality and payment incentives, how they're setting rates for the expansion in population.

But we want to understand -- you know, we can see what the rules are -- we want to see how it's sort of working in practice. We want to learn more about: are there aspects of the process that may impede achievement of the goal of providing value? And are there particular areas where oversight of the process can be clarified or strengthened? So this work, we hope -- the contract has not been awarded yet. It will be shortly. The work will be done, we think, in the first quarter of 2014. So again, in late spring or early summer we'll be reporting to you on the results of that work.

And the third area is data for understanding Medicaid managed care. We are in the midst of a project to assess the availability, completeness, and quality of managed care encounter claims data in MSIS at the state level. So MSIS, which I think we've already talked about a little bit today in terms of supplemental payments, but it's the database of Medicaid eligibility and claims that states submit on a quarterly basis and which CMS maintains.

It is supposed to include managed care encounter claims submitted by the MCOs to the states and

then from the states to CMS. This is part of our ongoing work to build capacity to analyze different types of data to inform Medicaid policy. The encounter data are sort of notoriously poor, and so, what our work is really trying to get at as a first step is where is it good and where is it not good and what can we use, you know, to inform our future analyses?

So we're looking at several things. We're comparing the enrollment information in MSIS to other sources such as CMS's annual managed care enrollment report. We're assessing the availability of encounter claims by type of service, by benchmarking them either to fee-for-service or to states that we know have good encounter data. And we're assessing the completeness and quality of key data fields on the claims, such as diagnosis and procedure code, to determine which states are submitting really complete data that we can use for analysis.

So at the end of the project, we'll have a set of metrics where we can determine which states have encounter data of sufficient quality for analytic purposes. This will really help support our analytic work on Medicaid managed care. I think staff will have a lot more confidence in what we're doing. And April, I think, will present -- maybe on this next month -- the work will be done in early spring.

So as managed care, you know, continues to evolve in Medicaid, the Commission will continue to assess characteristics and trends in Medicaid managed care programs and their impact on access and quality care for Medicaid enrollees. I would point out that we're broadening our work somewhat and we'll also report on these things in future meetings.

We're doing work on delivery and payment systems to address innovative value-based models and alternative purchasing methodologies. You know, like managed care, these models are intended to better

align payment with value instead of volume by changing provider incentives and promoting integration.

Unlike traditional managed care, a lot of these models involve working directly with providers around payment and delivery and coordination and risk. So it certainly creates new opportunities but also new risks. So, you know, we'll continue to examine all of those as the Commission looks for ways to move Medicaid to a more value-driven delivery system.

So that's the plan. If you have additional things we should be thinking about or thoughts on any of these proposed projects, feel free to share them.

CHAIR ROWLAND: To what extent will any of this work look at the duals demonstrations and the methodology there for paying for services?

MS. FORBES: We didn't sort of look at that work with this. I think because of the delay -- maybe Anne should answer this or someone else. I think because of the delay in a lot of the demos, that wasn't what we were sort of focusing on for the next few months.

CHAIR ROWLAND: But if you're looking at high-need populations and what happen to high-need populations, how they set their risk corridors and whatever in the dual demos would be another piece of what I would think you should look at.

DR. SCHWARTZ: Yeah. We can also think about -- I mean, Moira said 10 to 15, but I think we at one point increased the number of people in that meeting because it was hard to get 10 to 15, but we can also think about -- make sure that some of those kinds of plans or folks who are working on rate-setting for those populations are included as part of that inquiry.

CHAIR ROWLAND: Okay. So now I need to see hands.

[Pause.]

COMMISSIONER MOORE: Obviously a subject of great interest. I just wanted to ask a couple of questions about how or whether you'll be looking at different kinds of managed care organizations and also different populations, particularly the newer movement to cover SSI, disabled, duals, and so forth.

MS. FORBES: As part of the oversight project?

COMMISSIONER MOORE: As part of your oversight -- I mean, as part of all the monitoring activity, because -- and let me say, the reason is because I think there's a longer history in many states with serving the moms and kids population than there is with serving SSI populations, for example. So I wondered if we were going to try to slice and dice it a little bit so that the policy questions that may be arising around some of the more disabled populations would rise to the top quickly.

MS. FORBES: Yes. So for the oversight project, we are trying to get a mix of states. We're looking at states that have implemented a change in their program. We don't want -- we don't want a state that's sort of been going along for years and years. We're trying to get a sense of when someone is adding a population or adding a geographic area, because in a lot of states, that means moving into a more rural area.

You know, what kind of due diligence are they doing at the MCOs and is CMS doing of the state? So we are absolutely going to include several states in that mix that have either expanded to include the SSI population or to incorporate managed long-term services and supports into their capitated program.

And on the rate-setting roundtable, discussion of risk adjustment is a big element of that, and I think in particular as that relates to the more complex populations where there's more variance in expenditures across the population and you need to account for that when you're setting a PMPM.

COMMISSIONER MOORE: One other just quick question. The resources available to or allocated to the monitoring of managed care in a state, in my view, is really critical, and I don't know whether that's part of the monitoring effort or not. But it's been something that states have struggled with, too.

They know that and some of them do it differently than others. But in any event, I would just put that on the radar screen, too. The issue of what kind of state resources are available and being used to implement and monitor managed care.

MS. FORBES: No, I appreciate that. We have four particular areas of focus within the interview protocol for the states and one of them is state administrative capacity to oversee managed care.

CHAIR ROWLAND: That's come up several times in terms of not having the kind of staff background to do some of the actuarial work as well as to do some of the contracting work that's very different from paying claims. Okay. Donna is next.

COMMISSIONER CHECKETT: Well, this is -- you know, I always have great interest, too. I think obviously lots of us. I would just urge you -- I know that you have your foci identified, but there's some really interesting trends going on in Medicaid managed care right now that -- and a couple I'd like, if you can, to get input from your work group on -- and one is on integration and carve-outs.

And so, what we're seeing in a lot of states is finally a thoughtful look at the fact that you can't really separate your head from your body, and so, it makes sense to have integrated behavioral health and physical health. But there are still hold-outs on that. And then we're also seeing some states integrating long-term services and support, or LTSS, into managed care, including into the cap rates and into the coverage.

And I think that is really interesting because now we're really getting to a very complex population.

So I think just as your -- you know, more like in your general survey, I just think feedback on what states are doing in terms of those trends is one thing that would be of interest.

And then the other one -- because I haven't quite figured out how this is going to work, but it fits with your very last point. When you have a patient-centered medical home and you have an enhanced Federal match from the Federal Government for that, and then you have those same people on the PCMH who are enrolled in a Medicaid MCO, you know, what the findings are seeing, of course, is a whole fun set of discussions we won't get into here.

COMMISSIONER ROSENBAUM: Jim will.

COMMISSIONER CHECKETT: But Jim will. Jim and I, we're going to meet in the hall on this. But it is interesting, and I think you touched on it, you know, when you've got that and then you have managed care. You know, what is the point at which you have duplication of services as opposed to coordination. How can states address that? And then when you carry that to ACOs, you know, how do ACOs and the MCOs work together?

And again, you know, I know none of this falls under your side, but to me they're really kind of just like the latest trends I'm seeing in states. So I wanted to call that to your attention.

MS. FORBES: Thank you.

CHAIR ROWLAND: Okay. Next we have Trish.

COMMISSIONER RILEY: I would just sort of build on where the last two commenters were. On the administrative capacity issue, which I think is key, we ought to, if we can, find out what's contracted out and who does what, especially as we look at new populations. How much is the Medicaid agency conducting

oversight? How much is the sister agency of disability or aging conducting oversight? Or is nobody conducting oversight because nobody is really sure who's in charge?

And on the new approaches, I, too, am concerned about how this patient centered medical home trend plays out in managed care. And I don't know if it's possible in this initiative or in a future one, but I'm particularly intrigued with what appears to be a trend away from the traditional MCO. In the CCO in Oregon, 90 percent of Oregon's Medicaid population is now in their community care organizations, which are over managed care, as I understand it. Connecticut is moving into sort of a model like that, Vermont.

It seems to me we're headed maybe in a direction of looking at different alternatives besides the traditional MCO, and the more we could look at that, the better I think it would be.

CHAIR ROWLAND: Now we'll go to Burt.

COMMISSIONER EDELSTEIN: Trish just mentioned Connecticut, and in some work that I'm currently doing, I understand that as they were, I believe, the first state to go to entire managed care for the Medicaid population, they were also the first state to have completely removed managed care from their Medicaid program.

So it might be interesting to take a close look, a kind of case study look, at Connecticut to see what it was they learned about Medicaid or what their experience was that led them to either be the leader of what Trish is talking about, or just a complete outlier.

Another area of interest for looking closely at a case that Donna mentioned is the carve-out for dental. The states have really struggled with how dental fits with managed care. And right now is a particularly good time to take a look at how that's playing out, because there are probably as many states that have carved it out

as included it as just not dealt with it at all for managed care.

And then I wanted to add that of the three issues that you raised, payment, oversight and the data reporting, payment is already happening. We need to understand better how it's working. Oversight is critical. But I think of those three, the data reporting, at least for kids, is really critical because it's making hash out of the Medicaid 416. If you can't translate an encounter into a service, you really don't know how to report on the 416.

And I think that our ability as a Commission to track how well kids are getting the care that they are supposed to have under EPSDT is being influenced by -- adversely influenced by the failure of reliable reporting.

COMMISSIONER RILEY: Point of clarification. Robert's Rules, I can get in here. I do think it's not fair to characterize -- as I understand it, Connecticut is moving away from managed care. They may be moving away from the MCO, the traditional for-profit MCO to a different kind of model, but I think they're still --

COMMISSIONER EDELSTEIN: They're using exclusively ASOs across the whole program.

COMMISSIONER RILEY: Yeah, but they are still managing care. So I don't want to -- I think it would be -- they're not going back to fee-for-service. They're still managing care.

COMMISSIONER ROSENBAUM: It's more like a self-insurance.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: Well, actually, I mean -- I mean, it's relevant at this point because what I was going to say was that I think -- as opposed to just out of the blue.

COMMISSIONER CHECKETT: No one on this Commission is ever guilty of that.

COMMISSIONER ROSENBAUM: I think what we really could use at this point, going exactly to this exchange, is for the Commission to take on what is really a 21st century taxonomy of managed care. In other words, we are still working under the image that formed around the options that have been in the program, sort of organizationally starting actually in the 1970s and then going through the 1980s and into the 1990s when we sort of came up with this term managed care in earnest for a full service MCO.

But I think now we have different models of clinical and financial integration. And so, what we're calling managed care is really many, many different possible clinical and financial integration models, some of which would maintain the risk at the -- in an ASO model, I mean, it's maintained at the sponsor level and the ASO simply manages things, and has obviously some incentives.

But then there are models where there's really a pretty significant risk transfer to something that we call a managed care organization and it stops there. Others where now the risk is being down-streamed to group practices, which may be patient centered medical home networks, they may be ACOs operating under the managed care license, at least for certain populations.

In other situations, the same ACO may be a direct contractor to the Medicaid agency, say, for people with disabilities, so in other words, trying to capture for people what the market for clinical and financial integration under Medicaid looks like today, which is a somewhat different way of framing the issue.

And I think it's more useful in the end because there are questions that come up around clinical and financial integration that are getting answered, in the case of Medicare, let's say, and are not being answered in the case of Medicaid.

I mean, one of them, for example, would be, are there certain fraud and abuse safe harbors that should be extended to Medicaid arrangements just like we have now in the case of Medicare ACOs? Are there certain antitrust principles that ought to -- or ought not to apply to the Medicaid market?

And all of those questions turn on these issues of clinical and financial integration. And I just don't want us to get so caught up in the monikers of the moment that we're missing the forest for the trees here. The real story is more and more beneficiaries concentrated in arrangements where states and providers and potentially intermediaries are all trying to work together to integrate services better and manage within a budget.

And the variations over populations and delivery types and, you know, geographic types and whatever are enormous, and you can bring it back to the questions in Medicaid managed care, but I think that in terms of big thinking for Congress about Medicaid managed care, we ought to be pushing out the edges so Congress really can see what's going on, because there's no population now that's exempt from this and it goes to Diane's questions about duals or SSI-only populations.

Every population is inexorably moving toward a more clinically and financially integrated arrangement, and the question is, what do they look like, who are the big players. Some of the nationwide players, some of the regional players, and what are the new models that are emerging.

It's such a rich area that I think we want to try and really capture it here.

CHAIR ROWLAND: I have Patty next and then I'll go to Andy.

COMMISSIONER GABOW: So one of my comments sort of tees off Sara's but in a different way. I think there are all these varieties of financial and clinical integration and that means we're going to have to be

very careful that we don't mix apples and oranges as we look at the analytics.

So a primary care coordination system is not risk-based managed care. And what Colorado is doing with coordinated care is not risk-based managed care. So I think while I agree that we should define all of the variations of this clinical and financial integration, it also means we're going to have to be extremely careful about what's in what bin --

COMMISSIONER ROSENBAUM: Exactly.

COMMISSIONER GABOW: -- when we're drawing conclusions. And to that point, also, what Donna brought up is very important. As we talk about managed care, managed care that has a mental health carve-out is going to have hugely different implications for the patient than one with a carve-in. And the same way with dental. I mean, these carve-in, carve-out pieces, we're going to have to be very careful that again we're not mixing apples and oranges.

And the final comment I would make is about innovative care in this regard, which I don't think we have to -- we can't address just right now. But I think it is a growing, fertile area and that is the tiering of patients within a population and trying to match the care to their needs.

And I'm not saying at the edges, like sort of -- not big tiering like the disabled or the SSI, but if you just take, as we did at Denver Health for our CMMI, 130,000 users and say, Who's really a healthy kid? Who's really a healthy adult? Who's really a person with a chronic disease who's well-managed versus a patient with a chronic disease that's a train wreck?

And I think CareOregon has done some really interesting stuff about how, in a cost-effective way, do you start to think about aligning the appropriate care delivery model that actually is something you could

intervene in? I mean, if you're a train wreck but there's nothing that can be intervened on, that's a very different managed care patient than someone who you have an intervention for.

So I think that sort of putting that on our radar screen, this issue of patient tiering within the Medicaid population and how that affects the delivery model, is an important thing.

CHAIR ROWLAND: I'll bet you forgot.

COMMISSIONER COHEN: I practically did or now it seems even more extraneous, but I'll make it quick. First of all, great job. Really nice buckets of focus. Obviously this is a really important area and I second all the comments made to date.

I will just tell you, as I was reading the chapter and I came to the section on payment mechanisms, I got very excited, and then I realized that what you were planning to focus on was different from what I was sort of hoping for, which is that, you know, I think there is this maybe a common misunderstanding, maybe my personal misunderstanding.

But about, you know, there's this -- you know, a lot of talk at sort of like at high levels relating to the things about sort of the problems of fee-for-service and that fee-for-service encourages volume over value and that the solution to that is, you know, managed care in some form or another.

And I think from my own experience what I have learned is that within managed care, most payment to providers is still fee-for-service. And I don't know to what extent that is. Richard is shaking his head. So I would like to know if that is right or wrong or maybe how that's changed.

So in your efforts, I think it would be instructive, as we think about maybe shifting risk more directly to providers, and in other ways to really understand what payment to providers has looked like in managed care.

These, I think, are topics that very rarely sort of get discussed, and obviously there are -- you know, there are sort of proprietary components in there, too.

But just basic methodologies like how much is done by fee-for-service, how much is done by capitation, why? What are the lessons from that? I mean, you know, in theory, I think all of us would say, in theory, you would think that managed care would pay very differently than fee-for-service because they have the flexibility to do so, and yet, I think the reality is they don't so much.

So I just -- I think it may be a fruitful area for us to explore, at least to understand a little bit more what the real sort of like promise of -- you know, of sort of shifting risk is and maybe also to understand a little better what the barriers really are.

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: So I am interested in this topic, perhaps more than any other, and I would be glad to assist more directly if you'd have interest in that, going to the work group or the task force or some of that. I really virtually spent my entire career in this area and would love to help out in addition to what we do here.

I've also had some side-bar discussions with some of the staff last time and the time before of what they're doing and felt good about some of the states they selected and what I heard. Yeah, I would be glad to sit in.

CHAIR ROWLAND: Richard.

COMMISSIONER CHAMBERS: I'll be brief. I apologize for missing one of my favorite topics, like Mark. But as a matter of fact, I've been on a call with the Medicaid Director from California about the

duals demonstration and signing the contract today to move forward.

I got a chance to listen to some of the comments, and particularly Sara's extended comments. You know, managed care --

COMMISSIONER ROSENBAUM: [Inaudible.]

COMMISSIONER CHAMBERS: Very, very. And I'm sure everyone else's comments were relevant and smart because I have such smart colleagues. So I'll say I agree with everything everybody said.

But it is a great opportunity. I was really surprised when I was reading the draft report that we hadn't opined on managed care since June of 2011, and I was like, Wow, two years. It's hard to believe. And everything that's happened in two years. Managed care as just what we knew then and what we know now.

But it's the opportunity, as I see, of what is the true opportunities for managed care and it's not just to, as Sara talked about, passing risk to another organization and then just replicating, delegating things out and creating continuous stove pipes of delivery of services to an individual. It doesn't really get there. It's really the true integration of coordination of care.

And so, a lot of things have happened with the duals demonstrations and other things going on. There's a great opportunity and I think it's worthy of very close attention because it is at the heart of Medicaid delivery of services now with 74 percent of members in managed care. So I just wanted to make those comments. Thanks.

CHAIR ROWLAND: Robin.

COMMISSIONER SMITH: Just two comments to follow up on what Andy said about looking at what the fees are and where it's going, but we also need to link that to the outcomes. And, you know, are they

better even though we're paying less or more, whatever? You know, what are the outcomes?

And also to what Patty said when you were talking about tiering the patients, and maybe I see it in a different way, but I see a lot of opportunity to more individualized care because every person with a disability doesn't require once a week -- or once a week occupational therapy. Even a child with Down's Syndrome here is different from -- a child with Down's Syndrome here might need more or less or, you know, none at all.

So I like the idea of fine-tuning actually the individual opportunities that this can bring.

CHAIR ROWLAND: Well, great. Well, I think that you started by giving us an outline of what you were working on and what NORC was doing as a contractor and you asked for some additional advice and I certainly think you got it. But I think it just really does point out that the way in which services are paid for and delivered is really the fundamental part of the work of this Commission, and that the role of managed care in its various definitions is one that we really do want to focus a lot of attention on and understand much more about not only the payment levels and how providers are paid, but as Robin so aptly ended our discussion, with what does it really mean for quality and for the outcomes that we want to hold these plans accountable for in the system.

So Moira, you've got a lot of work ahead of you with your colleagues on the Commission staff.

MS. FORBES: Thanks, and I would point out that Jim and I are on deck for January, presumably to report back on the site visits we did to the states that are doing advanced models to integrate payment and delivery. So we'll bring fresh pens and thick notepads and be ready for the discussion.

CHAIR ROWLAND: Terrific. Okay. Well, we're going to take a ten-minute break and then resume.

[Recess.]

CHAIR ROWLAND: We are going to return from the issues of managed care now back to looking at the Children's Health Insurance Program and the discussion we've been having about at least coordination between the CHIP program and Medicaid and the exchanges.

And so we will turn back to Chris Peterson.

Session 9:

Review of Draft Chapter for March Report: Selected Issues in Children's Coverage under CHIP and Exchange Plans

* MR. PETERSON: Thank you, Diane.

So, similar to my last presentation, I'm going to begin by summarizing the draft chapter, which is in three parts. It begins with the key features of CHIP today, and then it tries to capture what the Commission had expressed in our last meeting about the broader context of children's coverage, looking to the future and then CHIP's future within that broader context. We'll be looking at that in greater depth in the June report but wanted to tee that up in a way that was consistent with the Commission's vision. So I hope that worked.

And I want to tip my hat to April Grady for doing that work and helping out.

And then, of course, Lindsay Hebert was also helpful in this chapter and the others.

And then we'll -- as part of this presentation, then we'll get down to the recommendations.

So the draft chapter begins with the key features of CHIP today, such as the number of enrollees and the total spending and noting that states have flexibility regarding program design and many other levers at their disposal.

Then, in looking at the future of CHIP, CHIP, of course, is a popular, successful program. It's focused on children's health care. But now the exchanges exist, and there is subsidized coverage through private plans, up to income ranges where it should now exist. It raises questions about what its future is -- of this program.

But one thing that the Commission has said is that lower-income families should have access to affordable coverage and appropriate benefits for their children. And, of course, defining affordable and appropriate becomes the challenging issue.

Then we begin in the chapter to talk about the near-term issues affecting CHIP and want to bring to you those potential recommendations in four issue areas, beginning with CHIP waiting periods.

In January, 37 states had CHIP waiting periods. It ranged from 1 to 12 months. And, during that CHIP waiting period in 2014, children may be eligible for subsidized exchange coverage.

We have reached out to states, and 16 of those 37 are eliminating those waiting periods.

Why are they eliminating them? The federal government put out regulations earlier this year, saying that CHIP waiting periods can no longer exceed three months and that there are a number of exemptions that states must apply to the waiting period.

And so, in light of that, some states have said, well, there are so many exemptions and there are going to be so few kids who actually will be subject to the waiting period, it doesn't merit us continuing these waiting periods.

And then the second issue is, as we'd talked about in the last meeting in some detail, the issue that children will churn during that waiting period. They could be eligible for exchange coverage, be in that

exchange coverage for three months and then churn out to CHIP. So this is this intra-year moving around of coverage.

So the proposed recommendation number 1 here -- and I'm going to stop after each of these and give some time for discussion -- is that Congress should eliminate CHIP waiting periods, that uninsurance and churning among children will be reduced in the 21 states that continue to use these waiting periods, that the administrative burden and effects of the potential disruption of children being in exchange coverage for three months and then on to CHIP or, potentially, being uninsured, that the purpose of this recommendation will be reduced that administrative burden and those effects.

There is also a lack of evidence that such waiting periods prevent crowd-out.

CHIP would be consistent then with Medicaid and exchange coverage in having no waiting period.

I did have a reviewer comment, though, that Medicare has a two-year waiting period for those who are qualifying on the basis of a disability. So that's something to note.

CBO has costed -- estimated the cost of this proposal at 50 million to 250 million dollars in 2015 and then less than 1 billion dollars over a 5-year period. So, relatively small considering multiple things -- the shrinking number of states that are continuing with the CHIP waiting periods and then to the extent that CHIP waiting periods exist, those individuals, many of them, are getting subsidized exchange coverage.

So it would be replacing one form of subsidized coverage with another. So that's why the cost is not that large.

So I'll stop now for any discussion on this particular recommendation.

COMMISSIONER CARTE: Chris, I thought one of the interesting things was the chart, if I could

find it -- your pie chart where it shows 4.5 or 6 percent of -- let me see if I can find it. I should have found it first.

CHAIR ROWLAND: The waiting period chart?

COMMISSIONER CARTE: Yes, the waiting period chart.

[Pause.]

COMMISSIONER CARTE: Right, I just wanted to stress that if you had this 4.6 percent that had employer-sponsored coverage within that 90-day period, that if you use that and try to just even make a modest, rounded estimate, it just emphasizes how low the cost of eliminating the waiting period would be.

Even though I know Dr. Dave is real concerned that we have a series of things that have low costs associated with them, I'm pretty sure that the administrative costs would balance that out quite easily, that it's a very modest cost.

And when you weigh the potential barrier, discontinuity of care for children or the issues family would face by that, for me, it's a pretty clear choice that we would want to see these waiting periods eliminated.

VICE CHAIR SUNDWALL: Well, just to respond to that, I want to tell you that Utah is one of the few states with no such waiting period. We have open enrollment in CHIP. It has worked there.

COMMISSIONER CARTE: Well, if it worked there, it could work anywhere then.

[Laughter.]

CHAIR ROWLAND: Well, also, I think the fact that 16 states have eliminated them, but clearly, there was prior statutory language that indicated that that was one way to prevent employer droppage. But we're in a different world now than when that provision was put in the statute.

Other comments? Denise?

COMMISSIONER HENNING: I would just think that this would go a long ways towards simplifying things. And I just think about on the other end of it, if you don't do this, it would be a billing nightmare.

And I can't imagine how much trouble it would be to be the exchange insurance provider and trying to deal with putting a kid on and then knowing that they're likely in three months to drop off. That just -- it doesn't make sense to do it that way.

CHAIR ROWLAND: Okay. All right, we'll move on to continuous eligibility, back again.

MR. PETERSON: So 12-month continuous eligibility, as I mentioned previously, allows states to waive the requirement that families report income changes. More than 30 states use 12-month continuous eligibility in CHIP. There is no explicit statutory authority for 12-month continuous eligibility for children in CHIP, unlike for children in Medicaid.

When we made -- when the Commission made this recommendation in March, things were a bit unsettled. CMS had a proposed reg to put CHIP 12-month continuous eligibility in the regs.

Since then, that was not finalized, but CMS has said that 12-month continuous eligibility in CHIP will remain a state plan option for CHIP.

So we have separated these two recommendations compared to last year when they were combined into one. We've already talked about it in the context of adults and Medicaid.

So, as we talk about this recommendation, the question is, does it merit your recommendation this time around, once more, for the -- however you say that word.

COMMISSIONER GABOW: Perseverance.

MR. PETERSON: And there is bipartisan legislation that has been introduced to mandate 12-month continuous eligibility for Medicaid and CHIP.

So, with respect to the recommendation, this says, to ensure current state flexibility continues for CHIP, Congress should explicitly authorize 12-month continuous eligibility for children in CHIP parallel to the current option for children in Medicaid. This would formalize the available current state plan option.

Again, research has shown that 12-month continuous eligibility reduces churning, therefore, leading to better health outcomes and reduced use of more expensive care.

As I mentioned before, it makes coverage more consistent with exchange and employer-based coverage.

And states implementing it -- again, this is to ensure that a choice, that a state option, continues. So this recommendation is not to mandate it.

So for states who implement 12-month continuous eligibility they would have less administrative burden but longer average months enrolled.

CBO has given us a cost estimate. Their assumption is that this is standard operating procedure in states, and so this recommendation to formalize it in the statute would have no additional federal cost.

CHAIR ROWLAND: Now I think since we have already made this recommendation, that this is an issue at which we should just highlight our previous recommendation and not necessarily make it sound as if we're taking a second vote.

So I think we want to, in our chapter, highlight this and remind the Congress of our previous

recommendation, but I would pull this from one that we actually to vote on tomorrow.

MR. PETERSON: So, moving to the third issue, it has to do with CHIP premiums below 150 percent of poverty. Medicaid premiums are prohibited below 150 percent of poverty, generally speaking, but are permitted in CHIP. Eight states have CHIP premiums below 150 percent of poverty, and you can see those states there on the slide. The monthly premiums for children in this income range are relatively small.

It is worth noting that we estimated in those 8 states nearly 400,000 children were subject to CHIP premiums below 150 percent of poverty prior to the ACA based on 2012 data.

But the ACA has changed many things, and a couple of these affect the number of children who would be subject to premiums below 150 percent of poverty.

One is, as Veronica mentioned, the stair-step issue. So children who were previously in separate CHIP programs between 100 and 133 percent of poverty -- they go to a Medicaid expansion CHIP program where, below 150 percent of poverty, premiums are prohibited. So that reduces the number of children in one way.

And then the second piece is that MAGI, the new income-counting methodology, requires Medicaid to ignore an additional 5 percentage points of income, so effectively expanding that 133 up to 138.

So now, really, when we're talking about below 150 percent of poverty where CHIP premiums could apply, that's going to be between 139 and 150 percent of poverty.

So our estimates are taking that into account. There would be potentially 110,000 children subject those.

Well, it's those eight states.

And just to remind you of the findings we had presented in the November meeting, to differentiate how children respond -- how their families respond to premiums below 150 percent of poverty versus above, and you can see that. Low-income families are much more sensitive to premiums, and for a given dollar amount it is much more likely to lead to uninsurance although there is some crowd-out effect.

So the proposed recommendation here is that, consistent with Medicaid, Congress should eliminate CHIP premiums for children with family income below 150 percent of poverty.

As the previous slide showed, CHIP premiums below 150 percent of poverty are much more likely to lead to uninsurance.

Eliminating these premiums would align with Medicaid policy.

CHIP premiums below 150 percent of poverty yield little revenue and now affect few children.

This recommendation would also eliminate CHIP and exchange premium stacking, at least for this population.

And CBO, because of the small number of children and states who are affected, estimates that this would score in federal costs of less than $50 million in 2015 and less than a billion dollars over 5 years.

So I look forward to your comments on that.

COMMISSIONER ROSENBAUM: So this is where my mind just sort of turns to sponges.

So, if the family -- let's put CHIP aside. There is no CHIP. So Medicaid goes to 138, and then you're in the exchange.

So, for a family with income below 150 percent, over the Medicaid level but below 150, for that family, under the Affordable Care Act, premiums are capped at -- what is it? Is it 2 percent of family income?

MR. PETERSON: Two or three.

COMMISSIONER ROSENBAUM: Yes.

MR. PETERSON: I think it's 3.

COMMISSIONER ROSENBAUM: Yes. So, essentially, the presence of CHIP pushes these families into a situation where they are, effectively, paying more than what the Affordable Care Act now, as official policy, says families of that income should pay, correct?

In other words, because you have to buy -- your family covers you and your spouse, but then because there is CHIP you have to go into the CHIP market and buy the CHIP coverage which is on top of whatever.

MR. PETERSON: Correct.

COMMISSIONER ROSENBAUM: So what we would really be saying is -- certainly, I mean, the effect is to eliminate certain premiums, but what we're really saying is that we're trying to align the CHIP premium structure with the Affordable Care Act premium structure so that families with incomes this low get the benefit of the maximum exposure that they would have, with the whole family unit inside the exchange, for subsidies.

MR. PETERSON: I'm not sure. Maybe, though, you're referring also to the next recommendation which is specifically on premium-stacking.

COMMISSIONER ROSENBAUM: So this is --

MR. PETERSON: So this is just for the below 150 percent of poverty.

COMMISSIONER ROSENBAUM: Right. But, if we put the two together, then what you end up with -- putting aside, obviously, children who need coverage in their right, where somebody is just buying the

coverage for the child, for the employer affordability problem or whatever.

But this plus the next --

MR. PETERSON: Yes.

COMMISSIONER ROSENBAUM: -- slide would have the effect of essentially making sure that families with incomes under 150 get the benefit of a congressional determination about what's affordable, at least in relation to premiums.

I mean, I realize there are separate cost-sharing issues, but -- okay.

MR. PETERSON: Yes.

COMMISSIONER RILEY: Like Sara, I'm confused about why we would have recommendation 3 exclusive of the others because I think you're dealing with the same population, 138 to 150, who will be in the exchange.

But my bigger concern, I think, is although we all know how poor 150 percent of poverty is, there's huge interest among many, many governors and legislatures in personal responsibility and skin in the gam.

COMMISSIONER ROSENBAUM: Yes.

COMMISSIONER RILEY: And I think there's one side about the move to uninsured. But then the question, I suspect, from those people would be, well, what if it was only $5 a month? You know, we want people to participate. We want people to contribute.

And I think the paper needs to be a bit more balanced and make the case for why those states think premiums are so important in terms of personal responsibility and behavior of populations and in terms of budget. Sharon pointed out earlier they do budget this stuff.

I think we just have to be a little bit more careful in understanding where the states are in this one.

And there's a real deep belief that no matter how poor people are they should pay something for their care, and I don't think we can just write that off.

COMMISSIONER ROSENBAUM: Well, that's why I was actually trying to reframe it in relation to --

COMMISSIONER RILEY: Yes, you're right.

COMMISSIONER ROSENBAUM: -- the affordability decisions that were made around the Affordable Care Act, mainly, that there should be a maximum amount of premium exposure for these families, and this is the amount.

So I'm wondering whether we might -- if we want to go this route, whether we might reframe the whole thing in relation to affordability under the ACA.

MR. PETERSON: Well, let me go ahead then with the -- should I go ahead to the next --

CHAIR ROWLAND: [Off microphone.]

COMMISSIONER MARTINEZ ROGERS: I fully agree with Trish, I think, and Sara. It makes people take ownership to their own health care if they're putting something into it.

And I think that that in itself should be a cost saver because then there's not so much relapse. They go when they're supposed to go the doctor and keep their appointments, we hope, maybe.

CHAIR ROWLAND: But these are premiums, not cost-sharing.

COMMISSIONER CARTE: Yes, I'd just like to point out I think I appreciate, Chris, that you separated these two areas out as recommendations. I think we're kind of jumping to talking about premiums

and cost-sharing all in one blow whereas this recommendation that speaks to premiums just below 150 percent, for the reasons that you have up there bulleted, plus the fact primarily that the premiums below 150 percent yield little revenue, affecting few children.

And I think as I look at table 5.3 and that there are only 9 states that have premiums that start below 150 percent I'd feel really comfortable supporting that recommendation.

But, when we look at the cumulative effect of premiums later above that, where the states do count on that revenue as an offset from premiums, it gives me pause.

CHAIR ROWLAND: Do you want move on -- Patty.

COMMISSIONER GABOW: I just want to make a comment about the skin in the game context.

COMMISSIONER RILEY: And I used it in quotes.

COMMISSIONER GABOW: I know.

Don Berwick just gave his regular IHI speech, and he made a comment that patients do have skin in the game; it's their own skin, when you're talking about their personal health and their personal well being and that we shouldn't forget that.

And I just think that we do need to not forget that.

CHAIR ROWLAND: I also think that on this recommendation we're really looking at premiums, which can be a barrier to enrollment.

And, while these children are at a very low income, they're just above where our Medicaid level is, that what we were looking at here was more to align their treatment with those just slightly below them at 138 percent of poverty. We should really think about that at this income level because that doesn't mean that in a

state that's covering kids up to 300 percent of poverty we're saying at this point they can't have premiums there.

Mark.

COMMISSIONER HOYT: Let me just real quick -- because I don't think anybody said this.

The administrative expense of chasing down $5 or $10 per kid per month is extremely high, and then the rate at which they move and relocate, and then if they don't pay, how are you going to go back and cancel the policy, and of that is a huge hassle for companies that cover them.

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: I just have to go on the record as saying that this makes sense, and I trust everything Mark says, but if the public gets a hold of this and says: What? It's only a billion over 10 years, so we can dismiss it.

That's not nothing the overall scheme of things. It just feels like it if you're talking in terms of $500 billion.

But, anyhow, it's just my caution again about everything we do; it's going to add up, and someone is going to take a calculator and figure out how much MACPAC is recommending we continue to spend.

CHAIR ROWLAND: But I want to go back to what Chris said earlier this morning about the nature of these cost estimates, and that's that they're a bucket. And they're not saying that this is $50 million; they're saying it's less than $50 million, and it's less than a billion.

So we don't actually even know what the actual cost of this is, but I'm pretty sure it's substantially less than -- I mean, we could ask each of these states how much they've collected in revenue. We'd probably find

that they spend half of their money on the administrative burden of it.

I think we should just be cautious about not saying this is a billion-dollar recommendation, but it's in the low bucket.

Okay?

MR. PETERSON: So I'm going to go to issue number 4, which is CHIP premium -- CHIP and exchange premium stacking.

So, as we've talked about, CHIP premiums are widespread. They were permitted to prevent crowd-out, particularly at higher income levels.

And the information that we showed at the November meeting showed how at the higher income levels CHIP premiums -- and this is discussed in the draft chapter -- are nearly universal, and they go up in dollar amount as you go up the income scale.

Thirty-three states used CHIP premiums in January, and they would apply to nearly half of CHIP children. But, beginning in 2014, as we've discussed, families can be subject to both CHIP and exchange premiums.

And it's also worth noting that to the extent CHIP premiums exist to prevent crowd-out, that parents who are eligible for exchange subsidies, it means that they have no offer of affordable employer-sponsored insurance.

And these were the examples that we had provided in November of, for the second lowest cost Silver plan, what the out-of-pocket amounts would be -- in the blue, for exchange coverage.

And then if you took the kind of typical monthly amount per child for a family of three with two kids,

then these are the amounts.

Now it varies by state. Some states do annual premiums; some do quarterly. Some have caps on the whole family amount, et cetera. But this is just one illustration.

CHAIR ROWLAND: But states don't have to charge premiums.

MR. PETERSON: Correct.

CHAIR ROWLAND: So one recommendation could be that states consider whether they should continue to have CHIP premiums given the availability of coverage in the exchange rather than requiring that that happen.

MR. PETERSON: Right. So 17 states and the District of Columbia do not charge premiums in CHIP.

So the possible recommendation is that Congress should eliminate CHIP premiums where parents have subsidized exchange coverage.

And the argument there would be that crowd-out of ESI is not an issue for these families because they are eligible for subsidized exchange coverage.

It would increase take-up of CHIP and exchange coverage because the effective costs would be lower.

The point that Sara raised, that it eliminates the possibility that CHIP would lead to higher out-of-pocket premiums compared to where CHIP was not available at that income level.

And it would mean less administrative burden for families in terms of they would not have to pay multiple premiums.

CBO has not provided us with a cost estimate and does not look to do so in the near term based on the

complexity of this particular recommendation because of the interaction of CHIP and exchange coverage and of the exchange credits. So, for them, that involves multiple groups within CBO and then dealing with the Joint Tax Committee. So they are working on bills and their updated baseline, and so this they do not expect to get to us anytime soon given the complexity of it.

As an alternative, it says, Congress should eliminate CHIP-exchange premium stacking by reducing families' out-of-pocket contribution toward subsidized exchange coverage by the amount of a family's CHIP premiums.

So this is a different way to get about this. Rather than making the state no longer charge premiums for these families, they would continue to get those -- the state would continue to get those premiums, but then the family would get the amount of the CHIP premium given to them through the exchange subsidies.

COMMISSIONER ROSENBAUM: They could become a credit, you mean?

MR. PETERSON: Correct.

COMMISSIONER ROSENBAUM: Right. So, if you would pay $720 on the CHIP side, that would be credited against what you owed on the subsidy side.

MR. PETERSON: That's right.

So it's trying to get rid of the premium stacking, but using the tax credits on the subsidies; it's going about that.

So it would allow -- it would eliminate that premium stacking and allow states to continue to charge their premiums.

The flip side is that then the federal government would be funding -- would be paying for -- the CHIP

premiums through those exchange subsidies, and that would require a statutory change to the Internal Revenue Code. And CBO will not be giving us an estimate on that anytime soon either.

CHAIR ROWLAND: So it appears to me that this alternative is extremely complicated.

COMMISSIONER ROSENBAUM: Well -- and more than that, why wouldn't every state at that point say, well, I'm getting --

CHAIR ROWLAND: Get rid of premiums.

COMMISSIONER ROSENBAUM: I'm getting rid of the premiums because why should I give the IRS money back. I'll just charge nothing on the CHIP side, and you know, the family will -- we'll just treat the families with tax credits as to what the family has to pay.

And so I think we're really stuck in sort of this point of what is CHIP's future in this system anyway. I mean, that's sort of the deeper, underlying question here -- how do you put these two together?

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: I think we need to go back to how Sara was framing this up because in many ways your solution about the states might be the best approach because it accepts the fact that many states believe deeply in premiums or some kind of cost-sharing. I think we need to build that more into the narrative.

We need to build more into the narrative that this cost-sharing out of the ACA is still significant. Even subsidized, it's real money for people. And they do have the "skin in the game."

And so to eliminate the CHIP premium, to ask states to do that, for those families that are already paying these significant out-of-pocket expenses seems to me to be a simple, easy solution and gets us the

ability to say cost-sharing matters and there's lots of it in the ACA.

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: Are we anticipating this problem before it's apparent?

I mean, we're expecting this cost, but I'm just wondering if we should let this exchange get up and running and see how it plays out with CHIP before we make recommendations here. We have no -- we're anticipating a problem that hasn't yet materialized.

MR. PETERSON: That's a fair point that we don't know exactly how many people are going to be affected by this. We can estimate, but to your question in the previous session, we don't know exactly how many people are going to end up enrolling and how many would, therefore, be subject to CHIP-exchange premium stacking.

So, if the Commission wants to wait and, you know, reconsider this --

CHAIR ROWLAND: Although we are seeing that in the enrollment numbers a large number of those enrolling are children, and many of them are enrolling through Medicaid and CHIP as opposed to directly in the exchange. So this issue is going to surface before the end of 2014.

Sharon.

COMMISSIONER CARTE: I just wonder in that regard if we have a clear way to measure or track the families who would not take up coverage through the exchange because of the family glitch, essentially.

MR. PETERSON: We have estimates from Veronica's presentation last month of that, and I forget what the numbers were.

COMMISSIONER CARTE: But there's a clear tracking of that and even -- I mean, this would sort

of play into that in the same way, right?

I mean that there would be an adequate subsidy, in effect, if the premium stacking effect -- or do we need a different category or tracking for that in order to be able to identify it going forward?

MR. PETERSON: You're talking about once people actually started enrolling in exchange coverage, or applying, how many people are going to be ineligible for subsidies because they are offered affordable employer-sponsored coverage; is that your question?

COMMISSIONER CARTE: No. I'm thinking about the families that go into the exchange, and then they see that they have to pay a certain premium, and then they say, well, but then I ended up with three kids in a CHIP program where I have an additional premium, and between those two I can't afford it.

Will we have a way six months from now to see where that happened?

It's going to affect, you know, the uptake of CHIP families into the exchange. And, if everybody is assuming that CHIP can morph into something else later, we need to be able to answer whether or not that's happening.

CHAIR ROWLAND: It, basically, is saying that if you're going to the exchange as a family, but your children are already eligible for CHIP, you continue to pay the CHIP premium, if there's a premium, and you don't get to offset that against your cost to be in the exchange.

COMMISSIONER RILEY: Isn't there another policy question? Would dealing with this issue now encourage more families to participate because it helps with the family glitch?

It takes away that additional cost of the CHIP premium. So it would serve as an incentive for a family to come in because they don't have to pay double, if you will.

CHAIR ROWLAND: Right.

MR. PETERSON: But the family glitch is affecting people so that they are not eligible for --

EXECUTIVE DIRECTOR SCHWARTZ: The subsidy.

MR. PETERSON: -- the exchange subsidy.

EXECUTIVE DIRECTOR SCHWARTZ: So it will be so expensive that the difference in the CHIP premium probably isn't going to make a difference.

I thought Sharon was asking, though, whether we would be able -- is there -- what data are going to be available to track parents who have kids in CHIP who decide to go bare, basically?

COMMISSIONER CARTE: Right, right, because Dave raised the question, are we looking at this too soon? Should we not wait and see?

I'm saying, but will we be able to see even if we wait?

MR. PETERSON: Yes.

VICE CHAIR SUNDWALL: Well, said, ma'am.

CHAIR ROWLAND: Well, we kind of have -- we have a tiered approach here.

So the first part on premiums that we have to think about is this issue of should children and families below 150 percent of poverty but above 138 be charged premiums. So that's recommendation 1.

Then the next level up is, should states be encouraged to not have premiums for individuals above 150 percent of poverty so that you can better coordinate the care and people are not in double jeopardy?

And then the next one is whether or not we should move to eliminate those premiums or -- well, I think alternative 4 is a little so complicated that it doesn't meet our simplicity test.

So then the next one is, should the states be required to eliminate those premiums?

And I think the implications are that if 16 states have already dropped them or -- that was waiting periods. If not all states are using them, then maybe there's a way to also look at what the effect is there.

But I think we should look at these as -- we should stack these recommendations and decide which pieces of them we're willing to go forward with.

MR. PETERSON: And so, if this one below 150 percent of poverty then has the smallest impact, the smallest number of states affected and, assumedly [sic], a smaller cost, although we don't know what CBO is going to estimate on the other one, then perhaps this one should be considered first.

CHAIR ROWLAND: I think we want to consider this one, and then I think we're looking at whether the next one should be encouraging states to eliminate premiums as opposed to requiring them, for simplicity purposes.

And then the third level would be requiring states to eliminate premiums.

EXECUTIVE DIRECTOR SCHWARTZ: So we add a new one to the list, and then we take off the last one.

MR. PETERSON: The only caution I would give on that last one is I am not sure --

CHAIR ROWLAND: The one we're taking off the list?

MR. PETERSON: No, the one you're adding, which is to encourage states to -- so are you talking about encouraging states to eliminate premiums altogether or to eliminate them for families where they would be subject to premium stacking?

And the reason I ask that specifically is because my understanding, from what I've heard, is that CMS

will not permit states on their own to waive CHIP premiums only for families where they qualify for subsidized exchange coverage. From what I've heard, that runs afoul of a provision in CHIP that says you cannot favor higher-income kids relative to lower-income kids.

UNIDENTIFIED SPEAKER: But Congress could do it.

CHAIR ROWLAND: The Congress could do it.

MR. PETERSON: But Congress could do it, but that's the issue -- is that this recommendation number 4 says Congress can do it. But, Diane, you were offering an alternative of, well, encourage states to do this, but that option may not be available to states.

So maybe really what you're saying is then --

CHAIR ROWLAND: Well, some states don't have premiums at all. Why is that option not available to states?

MR. PETERSON: You can eliminate them --

CHAIR ROWLAND: You can eliminate premiums, period. I didn't say premiums --

MR. PETERSON: Okay. So that was my original question of are you talking about eliminating premiums altogether or just for those where the family is subject -- where the family is enrolled in exchange coverage.

CHAIR ROWLAND: Well, it seems to me -- well, that then adds another calculation that has to go on about, you know, one set of -- well, you're right. That's not fair because if you're in a situation where you're in the exchange and you would be getting exchange coverage and you're paying premiums in one state and not in another state -- is what the inequity is that we're looking at.

People in the exchanges will be treated differently with regard to CHIP, depending on whether the state does premiums or does not do premiums.

UNIDENTIFIED SPEAKER: Well, that's true now.

CHAIR ROWLAND: It's true now, but what we're talking about is trying to recommend that they eliminate.

Trish.

COMMISSIONER RILEY: It seems to me in the new world, just as crowd-out is no longer an issue, this issue of treating families differently isn't really an issue because the families are still paying significant cost-sharing if we only deal with the people who are in the exchange coverage.

So, if we can reframe it, instead of looking only at CHIP and look at family obligation for cost-sharing, then you're not treating lower-income people differently than the higher-income.

So we just have to -- just as we reframe the crowd-out issue, we have to reframe this around subsidized coverage. And CHIP in this new world order is just part of a bigger set of premium assistance programs or subsidies.

COMMISSIONER CHECKETT: I'm jumping in. I really like that framework, and I think in some ways it's what we said about pregnant women, which is that we're thinking about them by their eligibility category instead of by looking at where are they just financially.

So it's helpful to actually make that connection.

CHAIR ROWLAND: Sara and then Robin.

COMMISSIONER ROSENBAUM: I totally agree. I mean, that's where I am, absolutely.

I'm sitting here trying to figure out how you operationalize that policy.

So -- and therefore, what we ask of Congress or recommend to Congress.

So you have a state where children are not charged premiums, and therefore, whatever the family pays for the adult portion of coverage in the exchange is what the family pays.

Then we have a state where the family -- I don't care what the income level is, whether it's from 133 up -- are charged premiums.

And, again, our principle is that families in the two states shouldn't be disadvantaged by a state's difference. It shouldn't matter. We're moving to sort of a national vision of affordability.

So what we're really saying is that states really can't charge premiums anymore.

I mean, that's the sort of net effect because if you're a state charging premiums, if you have two sets of families, each earning $25,000 a year, and in the exchange they each would pay $2,000 for the adult and spouse, and in Iowa, let's say, there's no premium charged, and in Nebraska there is a premium charged, don't we want the families to pay no more in Nebraska than Iowa?

Should we let state options burden beyond the upper limit of the scale? And the answer is no. If we really believe that the Affordable Care Act affordability test means something, then what were really saying is that states should not have the option of layering on additional premiums.

MR. PETERSON: I get what you're saying, except wouldn't the state response be, but we didn't get into this exchange game?

COMMISSIONER ROSENBAUM: Right.

MR. PETERSON: We have a CHIP program, and we charge premiums, and we cover up to 300

percent of poverty, say.

COMMISSIONER ROSENBAUM: Right.

MR. PETERSON: And you're not letting us roll back our eligibility levels --

COMMISSIONER ROSENBAUM: Right. So we have to --

MR. PETERSON: -- in the presence of this new exchange coverage.

So I think the state perspective would not be --

COMMISSIONER ROSENBAUM: Well, then our principle cannot be that we're trying to align with the ACA. That's my only point. You can't have it both ways.

Either we're trying to align with the ACA, in which case we say, look, it's now. Here's the national schedule.

Or, we say, you know, as long as there's a maintenance of effort requirement in place and the funding for CHIP is uncertain, then we really have to let states continue to decide certain premium issues even if it results in a higher financial burden in some states than in other states for the exact same family, unless we want to somehow limit the range of what states can impose.

Right now, they can -- what's the rule in CHIP? That you can't have premiums and cost-sharing that exceed 5 percent.

MR. PETERSON: Five percent of their income.

COMMISSIONER ROSENBAUM: So that really doesn't tell us what the premium range is.

I'm just really stuck on the fact that it's very hard to use the principle of alignment and get very far here.

We really have the principle that Sharon articulated before, of state flexibility.

And the question is, do we say: Look, we understand the need for state flexibility. So what we want to do is recommend nothing below 150 for children because there we think, as Diane was pointing out, it's such a close call to 138 and given the movement. But for 150 and over, we recommend that states continue to be able to impose a premium because we're not prepared yet to take that flexibility away from states as long as they have a maintenance of effort provision.

And CHIP is also uncertain. They don't know at this point how many years they're going to have to nurse the CHIP funds forward.

This is the problem. And I don't quite mean it this way, but this is the problem with continuing CHIP; you can't put the two principles together cleanly. So all we can do is sort of jury-rig something in the short term.

MR. PETERSON: My only amendment to that then would be we're not potentially recommending something for issue number 4 because what you said was recommend --

COMMISSIONER ROSENBAUM: [off microphone.] Right amount.

MR. PETERSON: Right, right, because what you said was recommend that programs continue to --

COMMISSIONER ROSENBAUM: [off microphone.]

CHAIR ROWLAND: I think that one of the things we could do here is not make a recommendation but instead point out the issue, the potential for stacking and the fact that we are looking at encouraging states to evaluate their premiums in light of the availability and the implications of coverage, and they have the option to eliminate them if they want or don't want to.

MR. PETERSON: And maybe also the Secretary's interpretation of being able to waive those

premiums for --

CHAIR ROWLAND: Right.

Sharon.

COMMISSIONER CARTE: During this period where we just have to jury-rig things for CHIP, I was wondering; would HHS be able to incentivize states to move to do away with premium stacking or reduce it?

COMMISSIONER ROSENBAUM: The answer appears to be no because they've already said that we can't give you flexibility there because it violates the don't discriminate against lower-income families. I don't understand the logic behind that analysis, but that's their position.

UNIDENTIFIED SPEAKER: We could suggest waiting.

COMMISSIONER ROSENBAUM: Right.

CHAIR ROWLAND: Right.

COMMISSIONER CARTE: But states can have a program where they have no premiums, right?

CHAIR ROWLAND: I don't understand why it's discriminating against lower-income families.

UNIDENTIFIED SPEAKER: It's discriminating against higher-income families, to waive it.

COMMISSIONER GABOW: Well, if you only waive it for the people in the subsidized group, that's why it's an issue.

COMMISSIONER ROSENBAUM: But if you are not charging lower-income families, then why is it discrimination?

COMMISSIONER COHEN: Because you treat them differently -- well, because you could have a

family at 150 percent of the poverty level who have to pay $500 a month for their private coverage, or something that's higher than the exchange, and they don't get their CHIP premiums waived. But a family at 250 percent of the poverty level, or something higher, simply because the adults get their coverage in the exchange, they would get the premium waived.

I think that's the argument around the discrimination. You could end up subsidizing higher-income families and not subsidizing lower-income families.

CHAIR ROWLAND: Oh, but that's when you're talking about the policy being only for people subsidized in the exchange.

If you're talking about generally looking at whether or not it makes sense in this new world to have children's coverage subject to a premium, it's different. There's no discrimination there if you eliminate it for all kids.

COMMISSIONER GABOW: Yes, but what Chris had said is they said it was discrimination only if you did it with the subsidized group.

CHAIR ROWLAND: With the subsidized group.

COMMISSIONER GABOW: But I want to understand. Did we just make a decision that we're not going to recommend anything about CHIP premiums below 150 percent of federal poverty?

CHAIR ROWLAND: No, we just talked about trying to deal with the premium stacking with it.

COMMISSIONER ROSENBAUM: I did put on the table whether we'd go back to your approach or separating the two because there are actually two really plausible, logical reasons for keeping them apart.

One other thing that I think is worth noting is --

COMMISSIONER GABOW: So the answer, no, we didn't make a decision.

CHAIR ROWLAND: No, we have not taken all the recommendations away.

COMMISSIONER ROSENBAUM: But the other question is whether you could get a hardship waiver from your -- if the parents can't afford their coverage because they're paying such high CHIP premiums, I assume that's a hardship waiver. That's another issue, okay.

CHAIR ROWLAND: Robin.

COMMISSIONER SMITH: I just need a clarification myself because this is not my thing. Are we talking about -- I mean, we are assuming that the parents are in the exchange.

I mean, is eliminating the premium for CHIP linked to the parent also enrolling in the exchange and having a premium?

CHAIR ROWLAND: No, we're trying to separate that out. That's where we get into the discrimination issue.

The problem occurs -- the stacking problem occurs because of the subsidy and the children's premium, but we were talking, Robin, more broadly about whether or not states should continue to have premiums for CHIP kids.

EXECUTIVE DIRECTOR SCHWARTZ: But you could have premiums -- premium stacking could exist between a kid being in CHIP and a parent having some employer-sponsored coverage. That would be a different kind of premium stacking, but we weren't talking about that because, presumably, that's not -- I mean, there's a tax expenditure for that, but there's not a direct subsidy for purchase of that.

CHAIR ROWLAND: Yes, but they can't have -- Trish.

COMMISSIONER RILEY: Sara may just have hit on something, though, because it seems to me, regardless of whether it's employer-sponsored coverage or exchange coverage, you can get around the discrimination issue by asking the Secretary to say a hardship exists when a family's payment is X percent of income.

MR. PETERSON: But the hardship is only to exempt individuals from paying the individual mandate penalty. So I don't --

COMMISSIONER RILEY: Oh, it's not -- why not do a hardship waiver --

COMMISSIONER ROSENBAUM: [off microphone.] literally unable in some cases.

COMMISSIONER RILEY: Right. But why couldn't you do the waiver under the CHIP program?

CHAIR ROWLAND: It would make coverage unaffordable.

COMMISSIONER ROSENBAUM: Because there's no comparable authority in CHIP.

CHAIR ROWLAND: Robin.

COMMISSIONER SMITH: Maybe I had that backwards.

COMMISSIONER ROSENBAUM: There's no comparable way.

COMMISSIONER SMITH: I guess I'm envisioning parents enrolling their children in CHIP but not getting insurance for themselves.

COMMISSIONER ROSENBAUM: That's exactly it. That's the issue.

COMMISSIONER SMITH: Are we linking -- are we saying you can't charge a premium because they're paying -- they're already paying over here when indeed they're not because they didn't enroll, but their children enrolled in CHIP?

CHAIR ROWLAND: Well -- but they'd be subject to a penalty if they didn't enroll.

COMMISSIONER SMITH: That's what I'm asking. Are we going to link that somehow so that we know they're paying a premium within the household, wherever it is, whether it's in the exchange, outside the exchange, if they're paying a premium already?

I don't know. I guess I'm very confused.

MR. PETERSON: So let me just try to restate what I think I've heard.

CHAIR ROWLAND: Oh, that will be interesting.

MR. PETERSON: So we've got these discrete CHIP premium-related issues.

Number 3 is fairly straightforward; eliminate premiums below 150 percent of poverty just to make it consistent with Medicaid, and it affects a few states.

Then we have this -- what was originally couched as an exchange-CHIP premium stacking issue.

But one could even go as far as saying, well, states, we want to encourage you to get rid of premiums.

But, as has been pointed out, states rely on these premiums, and there is a maintenance of effort in place.

So it sounded like folks were basically saying, this is an issue, and we need to talk about this in the chapter. But it doesn't sound as if there is a recommendation I hear bubbling up really regarding number 4.

UNIDENTIFIED SPEAKER: I think that's what confused me.

MR. PETERSON: And CBO is, too, so they couldn't cost it.

So everybody is in that boat.

So maybe we can --

CHAIR ROWLAND: And it's an area where we really want to monitor what is going on so we can try and find out to what extent this is a big problem.

MR. PETERSON: Right. So now let's turn back to recommendation number 3 on the 150 percent of poverty -- more discrete, narrower. Is the Commission interested in pursuing that, or do you want to wait on that given --

CHAIR ROWLAND: I think that's one of the recommendations we'll take up tomorrow.

MR. PETERSON: Okay.

CHAIR ROWLAND: Okay.

And now last, but never least --

UNIDENTIFIED SPEAKER: Always last.

CHAIR ROWLAND: But never least.

We're going to turn to a chapter being prepared for our March report on long-term services and supports. This is not a chapter in which we plan on recommendations but one that's a foundational chapter to begin our deliberations on long-term care services and supports.

And Angela and Molly will take us through their presentation, which is at tab 11 of your notebook.

Session 10:

Review of Draft Chapter for March Report:

Long-Term Services and Supports

* MS. MCGINN-SHAPIRO: Yes. Thanks, Diane.

So in the September Commission meeting, we had presented an overview of Medicaid long-term

services and supports to you. And, in your discussion during that session, you requested for us to take a step back and really focus on specific populations who use long-term services and supports, including information on who they are, what types of needs they have, what types of services they use, as well as the goals and outcomes specific to these populations and their care.

You also requested additional information on the delivery systems for LTSS, especially regarding managed long-term services and supports. However, we will not be presenting on MLTSS today, but instead plan to give you a more expanded presentation with more extensive information on the issues around MLTSS in the near future.

So, in this presentation, we plan to review the draft chapter on Medicaid's role in providing LTSS to vulnerable populations.

This draft chapter lays out the foundation for the Commission's future work on Medicaid long-term services and supports and, as Diane mentioned, includes no recommendations.

It begins by discussing what is Medicaid LTSS and noting how these services differ from medical care services and then describes the specific LTSS that may be provided by Medicaid and how states policies affect LTSS eligibility and benefits, including determining which individuals receive which services.

The chapter then shifts to describe the different populations of Medicaid LTSS users by age group and disability status. This section addresses the important questions that you have raised about who are LTSS users and what are the needs of these populations and what are the goals of their care.

The chapter then concludes by laying out some key policy issues that the Commission may address in future reports.

So, first off, I just wanted to remind you that it's important to recognize that Medicaid long-term services and supports, and the populations who use these services, are an important sector of the Medicaid program and, therefore, require specific attention.

And, as you can see from the figure, although the population that uses long-term services and supports is relatively small, at only 6 percent of total Medicaid enrollment, they account for 45 percent of Medicaid spending, and spending on LTSS alone for these enrollees accounts for 32 percent of total Medicaid benefit spending.

So, in order to appropriately examine Medicaid LTSS, we thought it is important to recognize the differences between medical care services and long-term services and supports.

Most long-term care is not medical care that takes place in a clinical setting, but rather, they are services and supports that provide assistance with basic health and personal tasks of everyday life.

While the outcomes for medical care focus on ameliorating or delaying the progress of a specific disease, an important goal in outcomes around LTSS also consider the quality of life for the enrollee. These quality of life outcomes are considered regardless of the enrollee's condition and, instead, focus around such concepts as choice or the autonomy of the enrollee.

And then, when you consider home and community-based services, the distinction from medical care becomes even more apparent. Medicaid HCBS outcomes and goals of care are highly individualized and person-centered, focusing on maintaining an individual's independence in the community. Therefore, HCBS needs vary substantially across subpopulations, and even within the subpopulation of LTSS users the need for services is reflective of the individual circumstances, such as the availability of housing or family and other

supports.

So the Medicaid statute requires only two benefits of LTSS to be mandatorily available for certain populations in the Medicaid program -- nursing facilities and home health services. The remaining long-term services and supports are optional for states to cover, including how the state chooses to cover benefits in terms of the scope and the breadth of services available for which subpopulations.

The two main types of LTSS include institutional LTSS, which tends to be more consistently defined across states and, therefore, has less variation in its coverage. Examples of institutional LTSS include nursing homes and the intermediate care facilities for individuals with intellectual and developmental disabilities.

In contrast to institutional LTSS, state coverage of HCBS is substantially variable and not consistently defined across states, and HCBS can include such services as out-of-home resident support services or in-home support services and many other types of services that are basically provided to allow an individual to remain in the home rather than being admitted to an institution for their care.

So, in order to receive Medicaid long-term services and supports, an individual must be determined categorically eligible based on age or disability and must meet state-determined financial and functional eligibility. While almost all states are required to cover individuals who qualify for a supplemental security income, or SSI, they also have a variety of optional eligibility pathways for individuals at different income levels and functional status.

Additional information regarding these optional pathways is covered in the chapter, but I just thought it was important to note that these optional pathways allow states to serve individuals with long-term needs who have higher levels of income than other Medicaid enrollees.

And, as you can see from the figure, the largest share of enrollees who use Medicaid long-term services and supports comes through the SSI eligibility pathway.

For some of the optional eligibility pathways, states may also set specific level of care criteria, and states also are allowed to determine the processes used in making these functional assessments.

So the variability in the eligibility policies, coupled with the variation in Medicaid long-term services and supports benefit design, means that the different populations have access to different sets of services even within the same state.

* MS. LELLO: And so, as you see in the chapter, we highlight the differences and patterns of LTSS use across the major subpopulations of LTSS users.

Now these subpopulations can be grouped into those distinguished by age as well as groups distinguished by disability or categories of conditions. As you can see here in this figure, the vast majority, or 91 percent, of all LTSS users qualify either on the basis of age, being over the age of 65, or on the basis of disability.

Now there's another 9 percent of LTSS users who don't qualify on the basis of age or disability, but they still use long-term services and supports. Those individuals who come into Medicaid through some other eligibility pathway, but they still might have a need for those services, and so they end up getting those services.

Medicaid LTSS has evolved over time to address these unique needs of each of these subpopulations. And the service use and patterns of current long-term services and supports is, in part, reflective of those historical trends and the way LTSS programs have been designed to target and serve these different groups

and the different unique needs and outcomes for the individual enrollees.

LTSS users can be broken down into three subpopulations based on age. Those are children, working-age adults and individuals over the age of 65. Within each of these groups, the types of LTSS they use is slightly different.

And, as you can see in this figure here, children and working-age adults tend to use more HCBS than individuals who are elderly. This service use may be influenced by certain Medicaid policies that target benefits to enrollees based on their age, for example, EPSDT, which has been interpreted to include LTSS and allow children to receive certain long-term services and supports that other adults enrolled in Medicaid might not have access to.

COMMISSIONER ROSENBAUM: Can I ask you one question?

MS. LELLO: Yes.

COMMISSIONER ROSENBAUM: Where you say nondisabled children, I assume what you really mean -- we were just sitting here saying, how could the nondisabled children using this be as big as the disabled children?

I assume what it is, is children who are covered because they are poor --

MS. LELLO: Correct.

COMMISSIONER ROSENBAUM: -- versus children covered expressly on the basis of a disability because the poverty population will include --

MS. LELLO: Correct.

COMMISSIONER ROSENBAUM: -- a lot of children who may have a disability.

MS. LELLO: Correct. So, in this figure, you see that disabled children under the age of 21 are roughly 6 percent of LTSS users, and nondisabled kids are roughly 7 percent. What that 6 percent reflects are children who enter Medicaid under either the SSI-related pathway, Katie Beckett, or some other disability pathway.

COMMISSIONER ROSENBAUM: That's why I wouldn't call the other slice, nondisabled children. I would call them children covered on a basis other than disability.

MS. LELLO: Thank you.

So, moving on from looking at our subpopulations by age, we also have LTSS users that can be grouped into subpopulations based on categories of disability or condition, and these subpopulations would include individuals of any age.

So, because of the way Medicaid long-term services and supports were developed, by replacing institutions that had been historically created to serve these categories of disabilities, these subpopulations are, in part, vestiges of historical institutional programs, and as such, you can break them down along those lines.

You have individuals with physical disabilities, who would otherwise qualify for nursing homes; individuals with intellectual and developmental disabilities, who would qualify for ICF level of care; individuals with serious mental illness, who would require inpatient psychiatric facilities; and then you have individuals who are medically frail, which would require a hospital level of care.

Now this could include individuals with serious medical conditions such as HIV/AIDs, or it could also include individuals with traumatic brain injury or spinal cord injury, TBI, SCI. But it could also include individuals who are technology-dependent or medically frail and have some ongoing health care costs related

to that condition.

Medicaid administrative data, unfortunately, does not readily distinguish these subpopulations, but specific programs and services have been developed to target these groups. And, in fact, 1915(c) waiver programs must target one of these groups or a subpopulation of them.

And, as you can see here, we have the 1915(c) waiver enrollment by target group, which can serve as a proxy to sort of get a general sense of the size of these subpopulations. And, as you can see, individuals with intellectual and developmental disabilities, and individuals who are aged or who have physical disabilities, are the largest enrollment in these targeted programs.

I would also note that other optional LTSS, including 1915(i) and some state plan services like targeted case management, require states to target a certain subpopulation in administering those services.

So the goals of the different services that target these subpopulations also vary and are reflective of both state priorities as well as individual needs and outcomes. For example, individuals with ID/DD might be in programs that are designed to support them or their families to perform, or acquire skills necessary to perform, major life activities and have a high quality of life whereas a program for an individual with serious mental illness might focus on rehabilitation and the recovery necessary for them to live as independently as possible.

We present all of this information in the draft chapter for you, and we conclude with highlighting several issues for future consideration.

Questions of particular interest to MACPAC include: What flexibility is important to maintain, in Medicaid, long-term services and supports, and is there a way to better organize and deliver these services?

We would be interested in hearing your thoughts as to whether there are any questions regarding the tone or specific topics or issues raised in the draft chapter.

CHAIR ROWLAND: Trish.

COMMISSIONER RILEY: This is such a challenging area to sort of get your arms around.

I like the last couple of charts where we really begin to break down with the waivers, who they are.

And I think you've done it nicely so that any audience will understand the complexity here, but I think with that simplicity we may have left on the table some big issues.

And I would actually like to reframe this discussion pretty considerably. I think we ought to lead with where we left off in March 2012, with that incredible finding that people with disabilities that are Medicaid-only are a bigger deal financially than duals because I think that's a very important finding for us, and then really drill down there.

I'm not prepared to talk about state variation as a good or bad thing until we address the role Congress plays in creating these silos. I mean, you can just list the programs available for these populations. It's very complicated.

And until I understand better what these services are, I think there is no bigger black box in Medicaid than services to persons with disabilities.

What do we mean by quality of life?

What's the measure of success?

What outcomes do we expect?

How do we measure it?

When you think about what Medicaid managed care has to perform to, what do we ask these providers to perform to?

And unlike the rest of the Medicaid program, where we tend to be purchasing services in a payment environment where other payers pay -- hospitals, physicians -- in a world that's a multipayer world, in the world of disability and long-term care, we are the payer.

Medicaid is the payer, and, yet, we know least about this.

And we've actually created a cottage industry with advocacy groups and providers who do wonderful work.

But we believe that that's the truth, and I don't think we've done enough analysis to really know what happens inside those services.

For me, the biggest thing that I think would really be an enormous move forward, besides our focus on persons with disabilities, is to recognize the world is moving increasingly to talk about person-centered care. So to talk only about long-term services and supports -- it feels like yesterday's news to me.

We really need to look at total spend on these populations on the medical side and the long-term side care, particularly when you think about some of their pharmacy use. And it's a really very diverse population, so kind of tough.

But I really think -- and when you look at waiver services and you look at the cost of waiver services, it doesn't tell us the whole story unless we know what these populations are getting on the medical side.

I think we're perilously close to creating for ourselves a new dual eligible type problem, where we have one set of programs and services being provided on the acute side, managed by the Medicaid agency, one set

of long-term care services and supports run by a sister agency, and we're not person-centered in this whole approach.

So I think we really need some significantly reframing of this issue and probably a bit more discussion about Olmstead and some of the forces that have put the states -- it is complicated. We've got a gazillion programs created by Congress. We've got Olmstead. You referenced the courts.

And I think we need to spend more time on it, but I don't think we can talk about whether standardization is necessary until we know something about what's happening with these services

And I think we're on the verge, from that first report where we got the data about the cost of persons with disabilities, Medicaid-only. If we can take that and really drill down, particularly where so much of the spend is, I think it would be of extraordinarily important value to the field.

CHAIR ROWLAND: I also think this is an area where we started down a road of trying to look at waivers generally and we got kind of tangled up with the 1115s versus the others. But, clearly, the long-term care services and supports is an area where multiple waivers doing very targeted, different things are there.

And to really begin to delve into kind of how the waivers work for this population is an area that I think is not for our March report but is an area where we can really begin to say: Well, what makes sense to be a waiver? What makes sense to be a state plan? Are there ways that things can be better integrated?

To just follow up on your point, Trish, but also on the discussion, it started with institutional bias, and then there was this attempt to provide more community-based care, but there's never really been a framework of how should the whole system work. And the disability population, I think, does get caught in this problem.

Robin.

COMMISSIONER SMITH: Big surprise that I'm going to say anything -- yes, I couldn't agree with Trish more.

The only issue I have about waivers, especially individual waivers that provide specific, let's say, autism services, is they're limited to a small number and I know that it's a huge expense for states.

But, to me, it's an access issue because you're cutting off probably the majority of the population that needs those services, too. You have a certain criteria, and if you meet that criteria, you get in.

And sometimes it's arbitrary because if you all remember when I came in, Sam came home with a G-tube, trache and IV that we were giving him at night. I actually had to make the IV up and inject all the things into the IV every day.

And, no nursing services because to get the waiver for in-home nursing services you had to have an MR diagnosis. And he was under three. You can't have an MR diagnosis unless you have an organic, or a brain, injury. So, yes, we had no nursing.

To me, that was just so arbitrary.

The other thing is that when you're on the list, somebody on the list might be getting services who needs a minimal amount where you have somebody else -- and this goes back to the tier system -- who really, really needs a lot of services to improve their life, and yet, they're not getting it because the list is already filled up. And they often age out before -- you know.

I understand why the states use them, for budgets, but I feel like there's got to be a better way of more efficient care because you're denying access to needed services when you use the waiver to eliminate services

to a certain amount of people that need them.

But I agree with you wholeheartedly.

I think this is an area where so much can be done. So I look forward to working on it in the future.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: I agree with what Trish and Robin said about maybe a retake on the chapter. I do think there are a couple things that I think are important that we think about going forward.

And, channeling you, Trish, I think we have to get back to, what are the goals of these services? And that gets to the issue that there are poorly defined criteria around home and community-based.

But I think without knowing what the goal is -- I mean, we know the goal of insurance is to get access. We have some things that, while we may be foggy about, at least we have something.

Well, what is the goal of these services? I think having clarity about that and pointing out where there isn't clarity, as you have about the home and community-based services, is really important.

I think this wait list issue -- Robin, I'm glad you brought that up -- is a big issue. Some of these wait lists are very long, and I would guess that there are some people who not only age out but go to another place in the universe before they get to these.

And so how long are you on the wait list?

It's one thing to know the wait list is this many. But, what's the average duration of the wait list?

And why do you get off? Is it mortality? Is it aging out?

Understanding those, I think, when we try to talk about access is important.

I like these state examples that you put in, and I wonder if that's something we should think of as

standard work in many of the reports.

We have to decide how we pick states. I mean, it can't be by a dartboard.

But, if you lived here -- I mean that example of you're disabled here, and then you move to college here, and then you get married, and you're here.

I mean, I think those examples, even though most of us here are data people, I think really put life to what is an otherwise very hard to understand thing. So I would encourage us to think about that as a sort of standard component of many of these chapters.

Then the last comment I will make is one that I know always generates much interest -- is when we're talking about institutional long-term care we have to begin to talk about end-of-life issues.

I mean, we cannot -- I know it's the death panel story. But, I mean, how do you talk about that and goals without having some discussion that as -- somewhere along the line somebody has to talk about when are we going to deal with these end-of-life issues.

We know the expenditures in the last six months of life, and I mean, I don't see how we can put our heads in the sand forever.

I mean, for some of us, it won't be forever because we're old and we're exiting.

But seriously, I think at some point we do have to say we don't want to make a decision about this, but it is something that has to be considered as you talk about long-term care.

COMMISSIONER MOORE: In your last bullet about organization and delivery of care, you touch on, in those words, some of the things we talked about earlier today around person-centered care, coordination and integration of care, and a focus on services and service delivery more than on something that

I consider a process, which is waivers or the controls within a waiver program.

I'm afraid sometimes when we get too far into waivers, which are a very, very important reality base for people in these situations -- but when we focus too much on that, we get away from a way to articulate new and innovative ways of delivering the services and setting the goals for individual people that will work for them.

So I'm not sure where I'm going with all of this, but I'd like to see more -- I guess it is a little bit of a reframing before we get too far down the road of looking at specific kinds of problems.

COMMISSIONER CHECKETT: Well, you know, I think I am feeling the same thing. It's a really fascinating area and a very well done paper.

I think one of the things that I've been struck with is that when you look at the different waivers and the different groups of people who fall within this large rubric is that they're really very, very different and the waivers are really tailored to meet their unique needs. A child who, or an adult who, has intellectual disabilities is really, really different from someone who has HIV/AIDS or a traumatic brain injury.

So one thing we might consider is separating those out and looking at that.

I think where I struggled a little bit with the chapter -- and I think it's an extremely interesting area, but it's so broad that I kind of felt like -- and I think it's what the other commissioners were saying, kind of -- where are we going with it?

And I think the issue might be that they're such different populations, and I don't think we can really lump them in other than in terms of large demographics.

But I really want to continue to dig in. I think it's extremely important. These are the people that

Medicaid is supposed to take care of, and I think that we really need to continue to explore it.

But they're just really different, and I think that's the problem I'm having with it.

COMMISSIONER SMITH: Just real quick, I just want to point out when we're talking about individualizing, which I agree we need to do, a lot of them are crossed over, though.

I mean, a lot of them will have developmental disability along with medically fragile because the situation of how they were born, or you might have mental illness that's complicating a medically fragile condition.

So that's something to think about, too.

COMMISSIONER CHECKETT: And if I could jump back in because, as Trish said, Roberts Rules of Order let you do this, I also meant to suggest -- you know, Diane and Anne, I don't recall if we've had someone come and speak to us, who is representing maybe these different groups. And I don't want to say LTSS because they're really different groups, but that might be something --

CHAIR ROWLAND: We did a while back, but we've not for a long time had someone back.

COMMISSIONER CHECKETT: And that might be something to look at, too.

And I think maybe the commissioners might want to think about -- you know, with no disrespect to any of these groups. But, is there a group that we're more interested in? And that might be where we would want to start because I think we have to be very careful not to just say they're disabled because there's a huge, huge range here.

CHAIR ROWLAND: Sharon.

COMMISSIONER CARTE: I'd like to diverge a bit from what you just said, Donna.

Of course, these populations are really different on the face of it, but something that jumped out at me is when the gentleman came from the Long-Term Services Commission, that they talked about the need for having some standardized assessment that would go over all these populations. And that goes to the issue of the black box. It would go to the issue of the goals.

When you look at your nice bar graph about the populations by disability or condition, the two that by far are the largest there are the ID/DD and the aged and disabled, both for whom cognitive impairment is a big issue.

And I think if we just had even the most basic of standardized assessments we would be able to tell which part -- a large part of this population probably just needs safe and supportive environments that foster independence to a certain extent, and then everything else could be layered on top.

But, in the absence of having any kind of assessment and database, we're just going to sit around and talk about these same issues another 20 years.

CHAIR ROWLAND: Okay, David.

VICE CHAIR SUNDWALL: I don't want to belabor this, but I just want to put on the table -- are we going to address anything related to fraud and abuse in long-term care services -- because I can tell you, as a practicing physician, it's amazing to me how aggressive these companies are in seeking authorization for services I didn't know my patients needed or wanted. But they will give you these forms to sign and quickly, please.

And it's amazing. There is a commercial side to this that is not insignificant as far as costs go, both for hospice and long-term care.

And it's just something for you to think about, but we don't necessarily have to focus on it now.

CHAIR ROWLAND: I would add durable medical equipment to the list.

VICE CHAIR SUNDWALL: Yes, it's amazing. You'd be surprised at these caring people and how greedy they are.

CHAIR ROWLAND: Well, I think we've saved you for last, but we've given you a lot of comments. And I think that this is clearly an area where we can reframe these issues.

But I do want to reemphasize the point that Trish started with, which is I think one of our strong points as a commission is our ability to talk about the program's responsibilities and coverage of people with disabilities and to really begin to look within the program at how their care is being coordinated.

We raised it in the managed care discussion because there is so much movement there to do integrated, acute and long-term services and supports.

So I think that this will continue to evolve as a very important contribution we could make to understand the high-need populations in Medicaid.

COMMISSIONER RILEY: I wonder if we ought not to go back to an old conversation we had at the beginning of the Commission, but a very important one, that especially in the ACA environment Medicaid makes private insurance work. If these populations were in the insurance pool, premiums would be pretty high. So it serves an extraordinarily important role with private insurance, and that's part of the reframing, I think. And it's also why it's so costly.

PUBLIC COMMENT

* CHAIR ROWLAND: Okay. All right. We have now come to the time when anyone from the

public who has a comment or suggestion to offer to the Commission should please come up to the mic and identify themselves, and we would welcome your comments.

[Pause.]

CHAIR ROWLAND: Otherwise, we hope we didn't freeze any of you today in the day. It got a little warmer as we went on but not a lot.

We've had a very full day, and so we thank you for attending. And the Commission stands adjourned from its public session.

* [Whereupon, at 4:16 p.m., the meeting was adjourned, to reconvene at 9:00 a.m. on Friday, December 13, 2013.]

MACPAC

Medicaid and CHIP Payment and Access Commission

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

Hall of States
National Guard Association of the U.S.
One Massachusetts Avenue, NW
Washington, D.C. 20001

Friday, December 13, 2013
9:25 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
RICHARD CHAMBERS
ANDREA COHEN, JD
BURTON L. EDELSTEIN, DDS, MPH
PATRICIA GABOW, MD
HERMAN GRAY, MD, MBA
DENISE HENNING, CNM, MSN
MARK HOYT, FSA, MAAA
NORMA MARTINEZ ROGERS, PhD, RN, FAAN
JUDITH MOORE
TRISH RILEY, MS
SARA ROSENBAUM, JD
ROBIN SMITH

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

Session 11: Review Actions on Churning

Chris Peterson, Director of Eligibility, Enrollment and Benefits 188

Session 12: Review Actions on Pregnancy Coverage

Amy Bernstein, Senior Advisor 195

Session 13: Review Actions on CHIP

Chris Peterson, Director of Eligibility, Enrollment and Benefits 206

Session 14: Review Actions on Supplemental Payments

Jim Teisl, Principal Analyst 219

Public Comment Day 2 241

Adjourn Day 2 243

P R O C E E D I N G S [9:25 a.m.]

CHAIR ROWLAND: Okay. Good morning, everyone. We are here today to continue the work of the Medicaid and CHIP Payment and Access Commission with regard to developing the chapters and materials for our March report, including recommendations.

The purpose of today's session is to really take a look at the proposed areas of recommendations that we would include in the March report. And we are going to systematically try to go through that this morning, and begin with looking at what some of the actions are with regard to stability of coverage with regard to implementation of the Affordable Care Act.

So if Chris Peterson would please join us at the table and review with us the proposed areas of discussion on this issue so that we can then engage in deciding what to include in the March report.

Session 11:

Review Actions on Churning

* MR. PETERSON: Thank you, Diane.

So where we had left off yesterday was with 12-month continuous eligibility. We had made a recommendation in March 2013 that encompassed making a statutory option for 12-month continuous eligibility for both adults in Medicaid and for children in CHIP. Because we have separate chapters on churning for adults and a separate chapter on CHIP, we've separated those out and your consideration for those.

With respect to the adults in Medicaid, we left off with the recommendation that there be a statutory option for adults in Medicaid to do 12-month continuous eligibility. So it is coming up on the screen

momentarily. I'm going to run it and go back one.

So the latest that we have, based on your feedback from yesterday and opening it up for additional discussion today is that the Congress should create a statutory option for 12-month continuous eligibility for adults in Medicaid, parallel to the current state option for children in Medicaid, and dropped the part about the matching rate, and we'll just discuss that in the rationale if you decided to adopt this recommendation.

CHAIR ROWLAND: Would you review for us the rationale for this recommendation?

MR. PETERSON: The rationale would be to reduce churning among adults, is one reason. Number two would be to make this option, which was available to states prior to 2014, to continue to make that available to states, because, as I -- perhaps unintended consequence, MAGI, eliminates this as a state plan option.

Number three would be to ensure that the matching rate for newly-eligible adults who would get 12-month continuous eligibility would continue to be available. So even though the Administration has said they would entertain waivers to do 12-month continuous eligibility for adults, there's confusion around what the matching rate would be. So this recommendation would have the effect of clarifying that. So those are some point.

CHAIR ROWLAND: And it would make the option available to the states for children now comparable for adults?

MR. PETERSON: That's correct.

CHAIR ROWLAND: So that families could both be maintained on coverage, should they both be covered?

MR. PETERSON: Right, right. So there's a scenario where currently states can do 12-month continuous eligibility for children, but not for adults, so as the income changes in the family, then that can make the re-determinations now happen at a different place simply because the state does not have that option to do 12-month continuous eligibility for the parents. And so, if this were adopted, then it would streamline things and make things simpler for families and for states as well.

CHAIR ROWLAND: So it would serve to promote stability of coverage, which is a phrase I like a little better than churning, since churning is a negative as opposed to a positive. I have Patty, then Trish.

COMMISSIONER GABOW: Well, I think since we really support those things that create alignment across programs, streamlining administrative issues, and access that is uninterrupted, and we know that when access gets interrupted, care gets interrupted, and then you end up with people in needs, et cetera. So I think this aligns with all our principles and would support moving this along.

CHAIR ROWLAND: Okay. Trish.

COMMISSIONER RILEY: I've always been concerned because I think -- I worry about costs in states and I've been concerned that this is actually an obligation for the exchange and it ought to be funded by that bucket. That said, I think that we ought to strengthen, from the paper and the work that Chris has done, we ought to strengthen the rationale to explain that many of these people wouldn't be able to afford the premiums, even though they're eligible for the exchange, because they're very borderline income folks.

And I think in the discussion and the paper we had yesterday, there was some compelling rationale about why continuous eligibility, in fact, saves money for the states and streamlines not just the administration, but does good things and cost-effective things for people, and I think we ought to make that real clear.

CHAIR ROWLAND: Okay.

VICE CHAIR SUNDWALL: I just wanted to -- that was the point I was going to make, is that all -- the CBO counted this as a cost item, not much, but over time, it would be something less than a billion. I do think that doesn't take into account the savings to states. If they didn't have the administrative burden of these people signing up and changing, that would be a savings to them. So I support this, also, in the spirit of administrative simplification.

CHAIR ROWLAND: Any other comments? Now, this is -- Denise.

COMMISSIONER HENNING: And I think, too, on the exchange side, that a private insurance company signing somebody up for a plan knowing that they're going to probably be dropping off in three months would be a nightmare for them administratively.

CHAIR ROWLAND: Since we have previously made this recommendation, we will move to include this discussion in our report and amplify the rationale from the March report and the previous recommendation.

MR. PETERSON: All right. So now turning to Transitional Medical Assistance, this is similar that this is reflecting what was said in our March 2013 report with a little bit of wordsmithing, but the point is essentially the same, that the Congress should eliminate the sunset date for extended Transitional Medical Assistance, Section 1925, as I said yesterday. That's Part 1.

And Part 2 is to allow states to opt out of TMA if they expand to the new adult group added under the ACA. So I can update you just a little on -- the cost estimate came in for this as $5 to $10 billion, if I'm remembering correctly, over five years -- I don't have that sheet in front of me -- which is much larger than last

year.

There has been Senate activity on this. The latest that we've heard is that the Senate Chairman's mark would extend TMA by five years and it has some opt out provision, but we have not seen the language that was approved by the Committee yet. So we're looking, just in case it's posted somewhere, but we haven't seen exactly what that opt out looks like.

And there are some other options that I had mentioned yesterday just in passing that one could just do a straight extension of TMA without any kind of opt out, and that would lead to some marginal savings over five years.

And then there was also an alternative to extend TMA and eliminate the sunset date and alter that opt out so that in addition to allowing states to opt out if they expand to the new adult group, to also require them only to be able to opt out if they replace TMA with 12-month continuous eligibility, which had a lower Federal cost to it.

CHAIR ROWLAND: So the question here is whether we want to modify or make any other alterations to our previous recommendation. Rather, we want to stand by our previous recommendation and have some discussion of the broader context in which this is now being considered. So it's open for the Commission's discussion. Sara.

COMMISSIONER ROSENBAUM: I think our recommendation remains a strong one. It sounds as if there may be some movement to extend TMA, but not indefinitely. I think that our recommendation -- what I like particularly about our recommendation is the extent to which it simplifies things for states. I mean, they would know that there is a Transitional Medical Assistance program, an extended program, and, of

course, if they expand Medicaid to cover all low-income adults, then they can simply consolidate at that point.

And I think that with the new much more -- in some ways, much more complex market that Medicaid operates in now, because there's a companion subsidy program, everything that we can do to reduce the number of eligibility categories while at the same time protecting people who need the coverage in the non-expansion states, clearly the Transitional Medical Assistance is going to be incredibly important.

And for that reason alone, I would favor a permanent extension. But here, you know, particularly allowing the states to expand to consolidate, I think, is the right way to go. And so, I see no reason for us to alter our prior position.

CHAIR ROWLAND: Andy.

COMMISSIONER COHEN: We all, I think, have talked about how strongly we feel about the points that Sara has just made about the importance going forward now that there is a spectrum of coverage options to eliminate and streamline as many of the sort of like complex ways that people get onto coverage, and now just say, Where is the place that you belong, what is the cost-sharing that is appropriate to you, and move sort of in -- move in a direction where those are the kinds of questions that we're asking, rather than some of the other like much more complicated questions that used to limit eligibility for health coverage for people who were, you know, who were generally low income.

So for all those reasons, I think this is an important recommendation. I think we do have to be aware of -- I mean, it's a substantial cost now, which it was not then, so I definitely would -- and there are many ways, as we have discussed here, to sort of go at this.

There's lots of -- I hesitate to use this term -- there's lots of low-hanging fruit in terms of streamlining.

So I think presenting in the paper options for getting at this same goal in a variety of different ways, some which might be less expensive, is also important. I don't think we should back away from a recommendation that we have made previously, but I think we should at least recognize that there might be some other options that move the ball forward and our somewhat less costly.

CHAIR ROWLAND: So leave our option as the broad approach, but acknowledge that there are other steps --

COMMISSIONER COHEN: Other ways to get at --

CHAIR ROWLAND: -- that could be taken in the interim. David.

VICE CHAIR SUNDWALL: Yeah, I would just like to support keeping it as -- I mean, just reinforcing our previous recommendation. I think we also just ought to acknowledge in the narrative of our report that our recommendation probably is, in part, responsible for the Senate taking this up and paying attention to it now. Is that a little presumptuous?

I think that we can take some pride in that. And the fact that they have done so, but also indicate that the Senate has moved forward on this, and we'll see what happens.

CHAIR ROWLAND: We hope the Senate will move forward.

VICE CHAIR SUNDWALL: Yeah. Maybe there will more different information by the time we get our report done. But anyhow, we don't need to make another recommendation on this.

CHAIR ROWLAND: I would recommend that if the Senate does take action in time to acknowledge any Senate action in the report itself, that I know we're on, when we get to the pieces being put to bed and to the press, but clearly keeping up on sort of where the debate on this is. And if they do take action now, it's

unlikely that this will resurface for a little while at least. Thank you, Chris.

And if Amy would please join us at the table so we can now review where we are on the issues of how to better coordinate maternity care coverage in Medicaid with some of the provisions that have been enacted through the ACA. Then again, if you would go through the recommendation and then really lay out for the Commission members to review again the rationale for that recommendation?

Session 12:

Review Actions on Pregnancy Coverage

* MS. BERNSTEIN: Yes. Based on your discussion yesterday, we have slightly reworded these recommendations. So this first recommendation is, to align coverage for pregnant women, Congress should require that states provide the same benefits to pregnant women who are eligible for Medicaid on the basis of their pregnancy that are furnished to women whose Medicaid eligibility is based on their status as parents of dependent children.

And the rationale for this is that currently, as we discussed yesterday, there are pregnancy-related pathways where women may receive only pregnancy-related services, which may be a less rich benefit package than are currently provided to this group of women, in particular, which are the 1931 women who qualify based on their status as being parents and being very poor who receive the full, for lack of a better term, benefit package and enhanced pregnancy benefits. Whereas, women who have higher incomes and qualify only on the basis of their pregnancy, do not receive -- may not receive, in some states, the full benefit package.

This recommendation would align these two pathways so that all women on Medicaid who either get services through being pregnant or through being very poor and having children have the same benefit

package, which is the full benefit package, and is considered minimum essential coverage.

So it basically streamlines eligibility, it equalizes the packages, and it eliminates the ability of states to, in the future, restrict services for pregnant women who they could, in the future, decide to only provide them with pregnancy-related services.

CHAIR ROWLAND: Okay. Burt.

COMMISSIONER EDELSTEIN: I think this recommendation is particularly sound from a clinical perspective, given that there's a greater and greater understanding of the interplay, the physiologic interplay that involves the health and welfare of the pregnant woman, as well as the possibility of the best possible outcome for the child.

I would like to use this opportunity, also, to point out that because adult dental benefits are not universally available to pregnant women and that there's a growing body of evidence that oral health, like any other part of the body, relates to pregnancy outcomes, that one of the shortcomings in current Medicaid policy, in some states, is the lack of dental coverage for pregnant women.

So while this goes a long way toward assuring that pregnant women receive the full benefits that they need to assure their own health and the positive pregnancy outcome, it's also another opportunity to recognize that the failure to provide adult benefits limits the capacity of fully realizing the intent of this recommendation.

CHAIR ROWLAND: Okay. David.

VICE CHAIR SUNDWALL: And you could do it for the benefit of our audience here and just to remind us, what is the difference between these? What are the benefits that would be added to the women who currently aren't allowed to receive that same equal benefit from the parents?

MS. BERNSTEIN: There are at least eight states which, on paper and in discussions, provide what are called pregnancy-related services only. It's not exactly clear what this means. As we discussed yesterday, we've tried to clarify it, but we do believe that there are some services that are not provided such as services in the postpartum period for things that are not related to the pregnancy.

One example was eyeglasses. We've heard hearing aids, we've heard other services. Again, the issue is that even if they are provided with full benefits, it's not considered minimum essential coverage, and that it could be that in the future, benefits could be restricted that are not related to the pregnancy.

CHAIR ROWLAND: Okay. Richard and then Sara.

COMMISSIONER CHAMBERS: As being someone who lives and works in one of the states that does provide only pregnancy-related services, I certainly support those because I think it's the right thing to do, and I look forward to it moving forward and eliminating the disparities in those states. So thank you.

CHAIR ROWLAND: Sara.

COMMISSIONER ROSENBAUM: Just to amplify a little bit on Amy's point, my biggest concern with this restriction always has been absolutely the postpartum period for women with serious and chronic health conditions like diabetes or hypertension or serious depression. You know, a strict reading of pregnancy-related would mean that once the baby was born, someone could come along and say, Well, it's not pregnancy-related anymore, the baby is born.

And obviously for the baby's well-being, not to mention the mother's, having her as healthy as possible coming out of the postpartum period is a good thing. And so, I think this is one of these cases where try as it might, the Commission staff have really wrestled with, you know, how to articulate what's excluded,

but I think this is a case where the evidence is so compelling of the importance of keeping women healthy through their postpartum period, and beyond, of course, but at least postpartum, that it's a loophole that just ought to be closed.

CHAIR ROWLAND: I would like to build on that a little bit, too, because I think that the reality that we should put into the rationale is that the children born to these mothers, because of the income eligibility levels for children are highly likely, even if the mother's eligibility ends, to be Medicaid-covered children. And therefore, it's an investment in trying to improve both the health of the mother, but especially the health and future health of a child who will ultimately, for at least a while, be a Medicaid-eligible child. Denise.

COMMISSIONER HENNING: Yeah, there's several other things that would be probably considered or not considered essential as far as when you go to pregnancy-related only, that they might not pay for somebody that has an earache, say, or nutritional counseling, centering pregnancy group care, because that's considered an enhanced kind of benefit, as well as the hypertension and depression that Sara mentioned.

Dental care, gallstones. If she has a gallbladder problem during pregnancy, you don't necessarily want to take her to surgery when she's pregnant, but then she's not pregnant anymore, but it still needs to come out. And then she may not qualify for Medicaid anymore, and it just might end up being a big problem.

But I'm also concerned about people that have multiple miscarriages, because once she has the miscarriage, then she's not on Medicaid anymore, but she may need -- you may need to investigate why it is that she keeps having miscarriages. So, you know, that's an issue, the inter-pregnancy care is a big issue that gets lost sometimes and can cause problems with the next pregnancy that she has.

So, you know, for all of those reasons, I think any time we can make sure that the care is as robust as

possible, to borrow Patty's term, then I think that that's the direction, because this is a really important thing for the health of the nation and for public health and for the children that are being born to these women, to make sure that the coverage is robust and that it is continuous and without a bunch of glitches in it.

CHAIR ROWLAND: Okay. Sharon.

COMMISSIONER CARTE: I'd just like to draw attention, as I did yesterday, to the figure that Amy has in her section that reviews nine different coverage options for the different routes that women have to take, depending on whether they're uninsured or under Medicaid or in CHIP or commercial coverage.

It's just -- there's just the amount of effort that state and eligibility staff have to take around these issues, as well as even clinical or provider staff. It just seems like, you know, we should everything we can to simplify it, along with what you said earlier. It just makes sense to me.

CHAIR ROWLAND: Okay. Robin.

COMMISSIONER SMITH: I said this yesterday, but I think it bears repeating, that there's so many conditions that are not necessarily pregnancy-related, and especially in behavioral health, that can have a huge impact on the outcome of the birth. When you're talking about, you know, a baby born at 26 weeks that didn't have to be, and then you have all these ongoing medical and developmental problems for the rest of that child's life, it's really just a huge savings to me in the long term if we cover those.

I'm really concerned about the behavioral health issues and not just the postpartum depression, although that's important. There's just so many other aspects that can affect the outcome of the pregnancy.

CHAIR ROWLAND: Okay. So, Amy, if you want to re-read the recommendation aloud and then we will take a vote.

MS. BERNSTEIN: To align coverage for pregnant women, Congress should require that states provide the same benefits to pregnant women who are eligible for Medicaid on the basis of their pregnancy that are furnished to women whose Medicaid eligibility is based on their status as parents of dependent children.

CHAIR ROWLAND: Okay. And, Anne, would you call a vote?

DR. SCHWARTZ: All those in favor or opposed indicate when called on. Sharon Carte?

COMMISSIONER CARTE: Yes.

DR. SCHWARTZ: Richard Chambers?

COMMISSIONER CHAMBERS: Yes.

DR. SCHWARTZ: Andrea Cohen?

COMMISSIONER COHEN: Yes.

DR. SCHWARTZ: Burt Edelstein?

COMMISSIONER EDELSTEIN: Yes.

DR. SCHWARTZ: Patty Gabow?

COMMISSIONER GABOW: Yes.

DR. SCHWARTZ: Herman Gray?

COMMISSIONER GRAY: Yes.

DR. SCHWARTZ: Denise Henning?

COMMISSIONER HENNING: Yes.

DR. SCHWARTZ: Mark Hoyt?

COMMISSIONER HOYT: Yes.

DR. SCHWARTZ: Norma Martinez Rogers?

COMMISSIONER MARTINEZ ROGERS: Yes.

DR. SCHWARTZ: Judith Moore?

COMMISSIONER MOORE: Yes.

DR. SCHWARTZ: Trish Riley?

COMMISSIONER RILEY: Yes.

DR. SCHWARTZ: Sara Rosenbaum?

COMMISSIONER ROSENBAUM: Yes.

DR. SCHWARTZ: Robin Smith?

COMMISSIONER SMITH: Yes.

DR. SCHWARTZ: David Sundwall?

VICE CHAIR SUNDWALL: Yes.

DR. SCHWARTZ: Diane Rowland?

CHAIR ROWLAND: Yes.

DR. SCHWARTZ: I have marked Steve Walden as not present.

CHAIR ROWLAND: And for the record, Donna left her signed vote voting in the affirmative.

DR. SCHWARTZ: So that's a yes.

CHAIR ROWLAND: So that's a yes in absentia and we'll have to figure out how we want to note that in any recorded vote listings.

DR. SCHWARTZ: Okay.

VICE CHAIR SUNDWALL: Can I just make one comment? I can't resist another opportunity to just say we are using Medicaid to promote public health, population health, with this kind of a vote. I mean, in any way we can, in fact, improve the outcomes of pregnancy, which is a common indicator in public health, I'm very pleased to see us kind of fill in this gap. So this is one example of how we're doing that.

CHAIR ROWLAND: Now we have a second recommendation that is a companion to the one we just voted on.

MS. BERNSTEIN: So this recommendation, as Diane says, is related to the first one. The recommendation is, the Secretaries of Health and Human Services and Treasury should provide that pregnancy-related Medicaid coverage does not constitute minimum essential coverage in cases involving women who are involved in a qualified health plan.

The rationale for this recommendation is that if women are already in an exchange-qualified health plan, they should not have to be disenrolled when they become pregnant. They should be allowed to maintain their qualified health plan coverage. This would reduce churning because women would not automatically be pushed into -- not pushed, but disenrolled and enrolled in Medicaid every time they became pregnant. It would be inefficient and would create churning.

It would also allow women who did choose to go into Medicaid for whatever reason, to be assisted in their cost-sharing for the exchanges. So this is sort of a reducing churning and reducing cost-sharing sort of addendum to the other recommendation.

CHAIR ROWLAND: And it would allow Medicaid to be then a wraparound to the qualified health

plan coverage.

MS. BERNSTEIN: Yes. Sorry.

CHAIR ROWLAND: Judy.

COMMISSIONER MOORE: And also, I think increase the likelihood of continuity of care from the standpoint of the beneficiary and provider, right?

MS. BERNSTEIN: It would allow them to maintain their qualified health plan network and, again, not to churn back and forth between Medicaid and the plan.

CHAIR ROWLAND: Which is part of the rationale for the recommendation.

Other comments?

Denise.

COMMISSIONER HENNING: Well, I just wanted to state for the record that this is -- it's nothing new, that the Medicaid wraparound for the exchange plans is very similar and is already done in the employer-sponsored insurance market. So providers already know how to do this. The Medicaid plans already know how to do this.

All this really does is it allows the women that are in the lower end of the income scale, who probably would be disadvantaged or have problems having the horizon of a new baby coming up -- it would allow them to have more coverage and make them more likely to attend their prenatal appointments if they didn't have the cost-sharing and if they weren't looking at a 20 percent hit when they went to the hospital to deliver that baby.

So I think it's a win-win for a lot of reasons.

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: We've had quite a bit of discussion on this, and I hate to bring up wordsmithing, but I'm just wondering if how we said this is clear.

The Secretary should provide that a pregnancy rider does not constitute -- I'm not sure what that means. Do we need to clarify?

In fact, if it can be done now, does this need something?

Maybe Sara can explain this, but I don't know if the wording gets at what we want to get done.

COMMISSIONER ROSENBAUM: Maybe we'd be better off with the word, specify. Specify that pregnancy-related coverage does not constitute minimum essential coverage in cases involving women enrolled in qualified health plans.

So we can actually even save a couple of words at the bottom.

So, women enrolled in qualified health plans, and change provide to specify.

VICE CHAIR SUNDWALL: I prefer that.

COMMISSIONER ROSENBAUM: Good catch.

CHAIR ROWLAND: Can you do that?

[Discussion off the record.]

VICE CHAIR SUNDWALL: That's better.

CHAIR ROWLAND: Okay? Is everyone prepared to vote?

All right, Anne, please call the vote.

EXECUTIVE DIRECTOR SCHWARTZ: Sharon Carte?

COMMISSIONER CARTE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Richard Chambers?

COMMISSIONER CHAMBERS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Andrea Cohen?

COMMISSIONER COHEN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Burt Edelstein?

COMMISSIONER EDELSTEIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Patty Gabow?

COMMISSIONER GABOW: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Herman Gray?

COMMISSIONER GRAY: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Denise Henning.

COMMISSIONER HENNING: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Mark Hoyt?

COMMISSIONER HOYT: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Norma Martinez Rogers?

COMMISSIONER MARTINEZ ROGERS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Judith Moore?

COMMISSIONER MOORE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Trish Riley?

COMMISSIONER RILEY: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sara Rosenbaum?

COMMISSIONER ROSENBAUM: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Robin Smith?

COMMISSIONER SMITH: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: David Sundwall?

VICE CHAIR SUNDWALL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Diane Rowland?

CHAIR ROWLAND: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay, and I'll mark Steve Waldren as not present.

And Donna?

CHAIR ROWLAND: Donna's vote for the record was a yes. Donna Checkett, yes, for the record.

EXECUTIVE DIRECTOR SCHWARTZ: Donna Checkett, yes, by --

CHAIR ROWLAND: By written ballot.

EXECUTIVE DIRECTOR SCHWARTZ: By a signed ballot, okay.

CHAIR ROWLAND: Thank you, Amy.

Chris, to return to the issues of Children's Health Insurance Program and CHIP.

Session 13:

Review Actions on CHIP

* MR. PETERSON: All right. So this recommendation has to do with CHIP waiting periods: To reduce churning and to promote continuity of coverage for children, the Congress should eliminate waiting

periods for CHIP.

Just as a reminder, in terms of the rationale, in January, 37 states had a waiting period. Sixteen states have now eliminated those waiting periods. They've said that they reason they've done so is because there are now new federal exemptions --

CHAIR ROWLAND: And the waiting period is the time an individual had to go without any health insurance coverage in order to be able to be covered by the program.

MR. PETERSON: Correct.

And the new federal regulations this year have new exemptions to those waiting periods at the federal level, and so, so few children will be subject to the waiting periods that the states that we've talked to said that's one of the reasons they are getting rid of it, in addition to the churning that would take place for children.

So, as we had talked about in November, as a family applies for coverage through the federally facilitated exchange, for example, if a child is in the CHIP income range, that federally facilitated exchange cannot determine that child's eligibility. That record gets transferred over to the CHIP agency.

If the waiting period applies, the child would actually be potentially eligible for exchange coverage. So their record would have to be transferred back to the exchange.

At that point, the child could be enrolled. The parents would have to select a plan including for the child.

Then once the waiting period has been satisfied, the CHIP agency would have to let the family know that they are now ready to be enrolled for the child in CHIP.

So this is another reason why states have opted to do away with the CHIP waiting periods, and so this

would be for us to recommend this to the Congress for those remaining states that have not, as of yet, gotten rid of those CHIP waiting periods.

CHAIR ROWLAND: And the original purpose of the CHIP waiting periods was to prevent crowd-out, which we found very little evidence of.

And this is also to really simplify and streamline administration. So it's reducing complexity.

So I would say, to reduce complexity and promote continuity of coverage as opposed to reducing churning --

MR. PETERSON: Okay.

CHAIR ROWLAND: -- as a suggested language change.

VICE CHAIR SUNDWALL: I want to back that up because when we met with MedPAC it was interesting that they asked us, what do you mean by churning? And these are pretty sophisticated people who didn't understand it.

In fact, Mark Miller said, we use it in a different term -- in a different context.

My grandmother thought it had something to do with butter, but anyway, I prefer that word. I don't think churning is commonly known, and it gets to the point if you talk about promoting continuous coverage.

CHAIR ROWLAND: Judy.

COMMISSIONER MOORE: I liked the way Chris --

MR. PETERSON: Just first, Diane, I want to make sure that we reflected what you were saying.

CHAIR ROWLAND: Yes.

MR. PETERSON: Okay. Thank you.

COMMISSIONER MOORE: I want to say I like the way Chris described what might happen if there were waiting periods, with people bouncing back and forth, and the likelihood of a child actually losing coverage in that scenario seems extraordinarily high. So I very much support this recommendation.

CHAIR ROWLAND: Maybe bouncing is a better word than churning.

Robin.

COMMISSIONER SMITH: Not just coverage, but also, it could be different providers. So for three months you might have to go to somebody that you don't know.

It makes sense.

CHAIR ROWLAND: Herman.

COMMISSIONER GRAY: Bouncing certainly seems much more childlike.

[Laughter.]

COMMISSIONER GRAY: This is a positive move. Certainly, the administrative simplicity that comes along with it is, I think, to be encouraged.

More importantly to me, of course, is an administrative reason for children having their care interrupted or their inability to access care in a timely and prompt way really is counterintuitive and doesn't really make a great deal of sense, cost-wise, or the impact that it has on a child and their family.

But we know that continuity of clinical care is positive in many ways -- the lack of interruption of care if the child is already receiving care, or access to appropriate primary or specialty physicians, decreases emergency room visits.

It's just really, I think, a very positive thing and would strongly support this recommendation.

CHAIR ROWLAND: I guess I would like in the rationale to also -- we could encourage the Secretary in the rationale, in the absence of congressional action, that we would hope that the Administration would do all it can to encourage the states to reduce the waiting periods.

Okay. All right. Shall we take a vote on the recommendation as it now stands?

All in favor or opposed indicate to Anne when your name is called.

EXECUTIVE DIRECTOR SCHWARTZ: Sharon Carte?

COMMISSIONER CARTE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Richard Chambers?

COMMISSIONER CHAMBERS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Andrea Cohen?

COMMISSIONER COHEN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Burton Edelstein?

COMMISSIONER EDELSTEIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Patricia Gabow?

COMMISSIONER GABOW: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Herman Gray?

COMMISSIONER GRAY: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Denise Henning.

COMMISSIONER HENNING: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Mark Hoyt?

COMMISSIONER HOYT: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Norma Martinez Rogers?

COMMISSIONER MARTINEZ ROGERS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Judith Moore?

COMMISSIONER MOORE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Trish Riley?

COMMISSIONER RILEY: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sara Rosenbaum?

COMMISSIONER ROSENBAUM: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Robin Smith?

COMMISSIONER SMITH: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: David Sundwall?

VICE CHAIR SUNDWALL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Diane Rowland?

CHAIR ROWLAND: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Diane, I'm marking Steve Waldren as not present.

CHAIR ROWLAND: And Donna Checkett has indicated her support in a written --

EXECUTIVE DIRECTOR SCHWARTZ: Okay.

CHAIR ROWLAND: Thank you, Chris.

Now, the next one.

MR. PETERSON: The next issue has to do with CHIP premiums.

Yesterday we had discussed two possible recommendations on CHIP premiums -- this one for CHIP premiums below 150 percent of poverty.

And then the second one was affecting CHIP premiums above 150 percent of poverty in certain cases where families had exchange coverage. Considering the Commission's desire to continue with certain flexibility, we are putting that one aside until we can get more evidence and see how that plays out for those families, whether it could be premium stacking.

And so the one we are bringing to you today with respect to CHIP premiums has to do with those that are charged to families below 150 percent of poverty.

As we discussed yesterday and in November, Medicaid prohibits premiums for children below 150 percent of poverty, but they are permitted in CHIP. Eight states are continuing at this point to continue with CHIP premiums below 150 percent of poverty. Those dollar amounts are relatively small, and the number of children affected is shrinking because of ACA changes.

As we talked about yesterday, our estimate was at 400,000 children -- nearly 400,000 children -- would have been subject to premiums in CHIP below 150 percent of poverty based on 2012 data.

But by the time the transition kids, the stair-step children, are moved out of separate CHIP into regular Medicaid and expansion Medicaid and expansion CHIP, those children between 100 and 138 percent of poverty are no longer subject to premiums. So, therefore, really we're only talking about that narrower income band between 139 percent of poverty and 150 percent of poverty.

So our estimate based on that would be only about 110,000 children in those 8 states.

And then this policy would -- this recommendation says: In order to align premium policies in separate CHIP programs with the premium policies in Medicaid, the Congress should prohibit CHIP premiums for children with family income below 150 percent of poverty.

COMMISSIONER CHAMBERS: Chris, could I just ask you a question?

This is my lack of knowledge probably, but 150 -- is there some magic about 150 percent -- because, I mean, if you were really going to align you could say at 138 percent and above in CHIP.

And I'm just curious; is there something with the 150 percent figure?

MR. PETERSON: I don't have -- the slide that I had yesterday showed the effect of premiums for children below 150 percent of poverty versus above, and the point of that was to show that the effect of premiums below 150 percent of poverty is much larger.

So, in other words, these families are much more sensitive to the effect of premiums, and for those children below 150 percent of poverty, it's much more likely to lead to uninsurance.

So I think those would be the compelling policy reasons. And then that would be in addition to the fact that Medicaid policy, for whatever reason, chose 150 percent of poverty as that line.

COMMISSIONER CHAMBERS: Okay.

MR. PETERSON: So it would simultaneously align with Medicaid, but then there's a policy rationale about that income level and how families below versus above 150 percent of poverty differ.

CHAIR ROWLAND: So the Medicaid statute currently prohibits premiums for individuals below 150 percent of poverty.

COMMISSIONER CHAMBERS: Okay.

CHAIR ROWLAND: So we're attaching to --

COMMISSIONER CHAMBERS: I see.

CHAIR ROWLAND: -- the existing Medicaid policy as opposed to picking our own level.

COMMISSIONER CHAMBERS: Exactly my question. Thank you.

VICE CHAIR SUNDWALL: Diane, can I ask a question?

Again, I'm kind of being sensitive to states' flexibility or not wanting to be so directive. But, what is the language in the Medicaid law? Does it say, prohibit?

Should we say prohibit, or is there another way of wording this that doesn't sound like the heavy hand of government?

COMMISSIONER CARTE: I think that the code says, shall not, but it's phrased in terms of cost-sharing, not exclusive to premiums per se.

COMMISSIONER ROSENBAUM: Right, the phrasing is cost-sharing, and it includes premiums, co-payments, deductibles, co-insurance.

So this just takes this one segment -- premiums -- and aligns on premiums.

VICE CHAIR SUNDWALL: Inasmuch as we are citing alignment with Medicaid, though, shouldn't we use the same language?

It's just -- no, no, I'm just thinking of this -- prohibit to me sounds heavy-handed.

COMMISSIONER ROSENBAUM: Oh, yes, we could certainly say -- but we sort of do. I mean, in order to align premium policies, Congress should -- you know. I mean, I'm not sure what we say there.

We could say, establish the same policy in CHIP that governs the Medicaid policy, and that would do

it, too.

But I think this is really clearer because we're saying what we mean.

VICE CHAIR SUNDWALL: We had eliminate and went to prohibit, but I think I like eliminate better.

Whatever you said --

COMMISSIONER CARTE: Well, I said it pertained to cost-sharing, as Sara did, but I think the problem is that Medicaid programs do sometimes have co-payments, you know, nominally. So I think we have to indicate it's about the premium.

VICE CHAIR SUNDWALL: That's okay, but I just don't -- I'm just wondering if there's another way of saying that. It's not a big deal.

CHAIR ROWLAND: Andy and then Sharon.

COMMISSIONER COHEN: I thought our discussion yesterday was very good, where we looked at this issue in the context also of premium stacking.

And I think the difference -- you know, the reason that we are moving forward with this recommendation and not the premium stacking is that while I think we were all fairly convinced that there is an issue with respect to families that are basically having to -- you know, are meeting a level of contribution set by Congress for the exchange. Then they are required to do an extra contribution based on their poverty level for CHIP.

And that was kind of like how we got into this topic, and I think that is real topic of concern.

I think where we got a little bit stuck yesterday is trying to understand the best way to address that

problem and where -- you know. Basically, it's just a question of cost and who should bear it.

I think we all felt like it probably wasn't appropriate on the family. On the other hand, there are other inequities with respect to families that might have employer coverage.

And it would be a real cost to the states and a real cost to the federal government to attack the larger problem.

So this is sort of, I think, a smaller way to get into this issue and one where the costs are smaller. It does align with an existing policy for the same kinds of family in Medicaid.

But I do just kind of want to point out that it really is related to a larger problem. I think we just need a little bit more work on how to address that larger problem, and this is a foray into that space.

CHAIR ROWLAND: Let me try a little different language and see if this may or may not work.

In order to align premium policies in separate CHIP programs with premium policies in Medicaid, the Congress should provide that CHIP premiums for children with family incomes below 150 percent of the federal poverty level not be subject to CHIP premiums.

SPEAKER: Provide that?

CHAIR ROWLAND: Provide that for children with family incomes below 150 -- provide that children with family incomes below 150 percent of the federal poverty level not be subject to CHIP premiums.

Or, you could just do the prohibit.

COMMISSIONER CARTE: Or, shall not be assessed a premium.

VICE CHAIR SUNDWALL: I like that -- shall not be assessed.

CHAIR ROWLAND: It's the same thing except it's phrased a little bit in terms of the children as

opposed to in terms of a prohibition on states.

Sharon.

COMMISSIONER CARTE: I wanted to reiterate Richard's point that as a state that does charge premiums I appreciate that premiums have been important to separate CHIP programs, both in terms of having state flexibility -- and I know certainly for my state it was part of our rationale as we expanded above 200 percent, that that was important as a cost offset.

I believe that that's still the case for many CHIP programs -- you know, the issue of personal responsibility and the fact that the family is subscribing to this rather than just receiving it.

However, I think that the income protection for these lower level families is important because you're raising the potential for an access barrier and, as we've said, we're aligning this with a Medicaid protection.

Even though I noted, Chris, in your table that only five states -- even though 8 states go below 150 percent, only 5 are actually collecting premiums above 100. So I think that might indicate they're starting that probably at 133, wouldn't you say?

Anyway, my point is that probably it's affecting far less children, and the administrative burden of doing it -- it's not -- it's probably not that --

CHAIR ROWLAND: It's really just children between 138 percent and 150 percent, which is a small band, but it does include lots of kids, and in a few states because in states where these children are already covered by Medicaid there are no premiums.

Okay. Any discussion? You want the old language back?

COMMISSIONER MOORE: I like this. It's good.

CHAIR ROWLAND: Okay. Then shall we take a vote?

EXECUTIVE DIRECTOR SCHWARTZ: Sharon Carte?

COMMISSIONER CARTE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Richard Chambers?

COMMISSIONER CHAMBERS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Andrea Cohen?

COMMISSIONER COHEN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Burton Edelstein?

COMMISSIONER EDELSTEIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Patricia Gabow?

COMMISSIONER GABOW: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Herman Gray?

COMMISSIONER GRAY: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Denise Henning.

COMMISSIONER HENNING: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Mark Hoyt?

COMMISSIONER HOYT: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Norma Martinez Rogers?

COMMISSIONER MARTINEZ ROGERS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Judith Moore?

COMMISSIONER MOORE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Trish Riley?

COMMISSIONER RILEY: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sara Rosenbaum?

COMMISSIONER ROSENBAUM: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Robin Smith?

COMMISSIONER SMITH: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: David Sundwall?

VICE CHAIR SUNDWALL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Diane Rowland?

CHAIR ROWLAND: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: I'm marking Steve Waldren as not present.

CHAIR ROWLAND: And marking Donna Checkett as in support of the recommendation.

Thank you, Chris.

Jim Teisl, for our final recommendation discussion on Medicaid, non-DSH supplemental payments.

Session 14:

Review Actions on Supplemental Payments

* MR. TEISL: Thank you. So I guess I'll start by reading the recommendations, slightly modified. As a first step toward improving transparency and facilitating analysis of Medicaid payments, the Secretary should collect non-DSH or UPL supplemental payment data at the provider level in a standard format that is

suitable for analysis.

As a reminder of some of the reasons for our rationale, we know that these non-DSH or Upper Payment Limit supplemental payments can be a large portion of total Medicaid payment to providers. In three of four states that we collected data from and analyzed, they accounted for between 30 and 50 percent of total fee-for-service hospital payments.

Existing Federal data sources do not generally include these data in a standard, analyzable manner; and thus, are not sufficient for Medicaid payment analysis. Some other parts of the rationale that we've discussed here, that the Federal Government provides the majority of Medicaid funding and without these payments, we are limited in our ability to assess the effects of payment policies on Medicaid program objectives such as efficiency, quality, and access to necessary services.

So collecting these data is a necessary first step towards, first, improving our understanding of Medicaid payment to providers, the effects of Medicaid payment policies generally, and in addition, you know, further considering even the role of these non-DSH supplemental payments in the program.

A couple of comments on some things that we slightly modified and we did add those words as a first step, and I think as we talked about yesterday, there are a number of limitations in our ability to analyze Medicaid payment data. But, you know, we've gone out. We've worked with data provided by the states. We've looked at aggregate reporting on the CMS 64, and these are at least $20-some billion in payments, and we don't know at this point to whom they go or in what amounts.

We also added that the data should be in a standard format that is suitable for analysis. We talked about the fact that collection of Medicaid payment data is already required via the MSIS, according to the

statute. We also talked about the fact that beginning this year, CMS is requiring states to report or to demonstrate compliance with the upper payment limit rules, and part of that demonstration of compliance includes submitting data on payments including both base payments and supplemental payments.

However, those data are not, at this point, required to be submitted in a standardized format, nor are they compiled and available for analysis. And these are some of the things that we would discuss in the discussion following the recommendation in the chapter.

CHAIR ROWLAND: Okay. Discussion? Trish, Judy, Patty.

COMMISSIONER RILEY: I think Jim has done some wonderful work here, and the staff, and I think it's so fundamental to our charge. It's been so frustrating for us, as we think about Medicaid and CHIP Payment Commission and we don't know the fundamentals of hospital payment, which is such a big part of Medicaid spend, that this is particularly important, particularly where we focused it on a standard format where we can really use the data.

It's very important work and you've shone a big light on it. And I would reiterate that we're not in any way questioning the multiple appropriate and legal ways that states fund their Medicaid programs. That's not at issue here. What's at issue is how payment is made to providers, and I think this will be a step in the right direction. You've done great work to sort of shine a light on an area where it's been another black box exactly how these payments work.

CHAIR ROWLAND: Judy.

COMMISSIONER MOORE: I'm very much in favor of this recommendation. I like the addition of the phrase at the beginning that we talked about yesterday, and I very much like the chapter that Jim has

written and the rationale that he and we have developed.

I have a silly little nitpicky thing, which is we've got the word analysis in there twice. And I don't know if you could say facilitating review of Medicaid payments or if that's too wishy-washy. Do you have any thought about that?

VICE CHAIR SUNDWALL: That's a good point.

COMMISSIONER MOORE: It can be just repetitive, but, I mean -- examination? They're fixing it.

CHAIR ROWLAND: We'll see what it looks like.

COMMISSIONER MOORE: And I really -- I didn't mean to be nitpicky, but it kind of leaped out at me.

VICE CHAIR SUNDWALL: No, it's a good point.

COMMISSIONER CARTE: Or we could say it promotes payment review.

CHAIR ROWLAND: Another word could be facilitating understanding.

COMMISSIONER GABOW: I like understanding.

VICE CHAIR SUNDWALL: I like that, too, because we don't -- we don't understand.

CHAIR ROWLAND: We don't understand them and we want to.

VICE CHAIR SUNDWALL: That's better.

COMMISSIONER MOORE: Definitely better with understanding.

CHAIR ROWLAND: Okay. Burt after Patty and then to Richard.

COMMISSIONER GABOW: Well, I just second what Trish says. Clearly, these payments are legal

and clearly very important ways in which states are able and providers are able to deliver access, which is the other part of our name. But I think that any time we're talking about money and Federal expenditures, there should be transparency and we should be able to analyze these payments, the provider fee payments, the states' use of UPL, all of these things.

I think it's really good that you pointed out that this doesn't get us to the end game, but it is an important first step when you're talking about the amount of money that we're talking about. It's non-trivial. So I strongly support this move towards greater understanding of the payments.

CHAIR ROWLAND: Richard.

COMMISSIONER CHAMBERS: Okay.

CHAIR ROWLAND: And then Sharon.

COMMISSIONER CHAMBERS: I'm going to piggyback on my esteemed colleague, Ms. Gabow -- Dr. Gabow, excuse me -- is that the same thing of saying about transparency is, you know, for years as a CMS person is looking down from the Federal perspective at states and using legal avenues for generating revenue and then how it is then used as supplemental payments has always been a black box that is certainly worthy of it.

Then now at the ground level as being in states that use managed care is how these hospital payments flow through managed care organizations. And the frustration of just how, you know, even at the state level, decisions are made about what the money is actually used for and what it's tied to.

You used to have more transparency of what is actually going on, because again, when you're talking about $20 billion in revenues is to have a much better handle on making sure, you know, is the charge of this

Commission of access and payment, of making sure that payments are going for increasing access for beneficiaries. So I totally support that. This is a first step. It's not going to be the only step. It certainly is a first step in going forward.

And then a second comment, which Robin and I were having a sidebar, when you look at, at the end, it says, standard format that is suitable for analysis. Analysis by whom? I mean, it could be collected and then it's like, does it stay in a black box in CMS for analysis? I mean, it doesn't say it's suitable for analysis, because we had formerly said by the public, I think. But, I mean, I just -- I think it's --

VICE CHAIR SUNDWALL: It's public analysis.

CHAIR ROWLAND: Well, I don't know what public analysis is. We want the data available for public use, but --

COMMISSIONER ROSENBAUM: How about -- yes, I think public use and analysis. Made publicly available and suitable for analysis. I mean, the public availability, I think Richard's right to catch it, that our discussions yesterday suggested that we want to be sure that there's access to the data as well. So if it's in the standard format, payment data at the provider level that is made publicly available in a standard format that is suitable for analysis.

COMMISSIONER CHAMBERS: Yeah. I want to make sure to attribute that to my esteemed colleague, Ms. Smith, who picked up that little clause.

CHAIR ROWLAND: So we're taking out public analysis, right?

COMMISSIONER ROSENBAUM: Yes. Make it standard format that's available to the public.

CHAIR ROWLAND: In a standard format publically available and suitable for analysis.

COMMISSIONER ROSENBAUM: Yes, or that enables analysis.

CHAIR ROWLAND: Publicly available at the end of the sentence?

COMMISSIONER ROSENBAUM: No, because it doesn't -- I tried that mentally in my head and then it amends analysis. So I think what we want to say --

CHAIR ROWLAND: That the Secretary should collect and make data publicly available, no-DSH. The Secretary collects and makes publicly available.

COMMISSIONER ROSENBAUM: Yeah, yeah, that's good, that's good.

CHAIR ROWLAND: To enable analysis.

COMMISSIONER ROSENBAUM: I think it ought to be suitable for framing.

DR. SCHWARTZ: You've seen Jim's office?

COMMISSIONER ROSENBAUM: Think of all the word changes that Tolstoy went through, you know? We're not Tolstoy.

DR. SCHWARTZ: We have gotten better at the wordsmithing, we have.

CHAIR ROWLAND: All right. Herman, you were in the queue already.

COMMISSIONER GRAY: I would just also agree with my colleagues that better understanding these payments is core to the MACPAC charge. You know, I think we heard yesterday that states currently, obviously, know what they're paying and that these payments are part of a states' submission, state plan submissions.

The only other comment I would make is that there's certainly some evidence that these types of payments are particularly critical for safety net providers. I think as we go forward and better understand

these, that we need to keep that in mind.

CHAIR ROWLAND: And we also wanted to be sure in the rationale that we talked about needing to look beyond that at DSH and other issues, that this was just what we can define a little more about what we meant by a first step. David.

VICE CHAIR SUNDWALL: I hate to prolong this, but if I were reading this as an outsider, I don't know if I'd know what "at the provider level" means. What do you mean, at the provider level?

MR. TEISL: And perhaps this is something that we can clarify further in the discussion, but what we mean is we would see the payments that are made to each individual provider and in what amount, rather than in the aggregate. We wouldn't just see a state-level aggregate total of non-DSH supplemental payments. We would see the payments at the provider level.

CHAIR ROWLAND: So you would know how much a hospital --

MR. TEISL: An individual hospital.

VICE CHAIR SUNDWALL: Should we say that?

CHAIR ROWLAND: I think you can say that.

VICE CHAIR SUNDWALL: A hospital facility?

CHAIR ROWLAND: Well --

VICE CHAIR SUNDWALL: There's a lot of providers. That's kind of an obtuse term.

CHAIR ROWLAND: I would think that we would be better off to define what we mean by "at the provider level," just in the discussion, since we don't want to leave out -- if we say -- we don't want it to say hospitals and leave out the fact that nursing facilities account there, and then as Jim said yesterday, in some

places there are large group practices that are there. So I think we can explain that more specifically.

And most people reading it very generally probably won't even know what non-DSH or UPL even refers to. So I think we're already at a different level. Any other comments on this particular one? All right. Then, Anne, would you call the vote?

DR. SCHWARTZ: Sharon Carte?

COMMISSIONER CARTE: Yes.

DR. SCHWARTZ: Richard Chambers?

COMMISSIONER CHAMBERS: Yes.

DR. SCHWARTZ: Andrea Cohen?

COMMISSIONER COHEN: Yes.

DR. SCHWARTZ: Burton Edelstein?

COMMISSIONER EDELSTEIN: Yes.

DR. SCHWARTZ: Patricia Gabow?

COMMISSIONER GABOW: Yes.

DR. SCHWARTZ: Herman Gray?

COMMISSIONER GRAY: Yes.

DR. SCHWARTZ: Denise Henning?

COMMISSIONER HENNING: Yes.

DR. SCHWARTZ: Mark Hoyt?

COMMISSIONER HOYT: Yes.

DR. SCHWARTZ: Norma Martinez Rogers?

COMMISSIONER MARTINEZ ROGERS: Yes.

DR. SCHWARTZ: Judith Moore?

COMMISSIONER MOORE: Yes.

DR. SCHWARTZ: Trish Riley?

COMMISSIONER RILEY: Yes.

DR. SCHWARTZ: Sara Rosenbaum?

COMMISSIONER ROSENBAUM: Yes.

DR. SCHWARTZ: Robin Smith?

COMMISSIONER SMITH: Yes.

DR. SCHWARTZ: David Sundwall?

VICE CHAIR SUNDWALL: Yes.

DR. SCHWARTZ: Diane Rowland?

CHAIR ROWLAND: Yes.

DR. SCHWARTZ: Marking Steve Waldren as not present.

CHAIR ROWLAND: And I would note that Donna Checkett voted yes and she underlined the word yes for this particular recommendation.

DR. SCHWARTZ: Let the record reflect the exclamation point.

CHAIR ROWLAND: Thank you, Jim. And thank you to all of the staff who put together not only the areas here where we have recommendations, but the exhaustive work that went into many of the other

pieces of our analysis, including especially the materials that are going to be part of looking at the access indicators that Anna Sommers presented yesterday, the long-term care chapter work where we want to really delve more deeply into some of the issues around long-term care to really try and queue up our work on long-term care for our June report, along with perhaps using some of our time to bring in others to talk to us beyond.

We did have the Long-Term Care Commission at our November meeting, but I think we'd like to also begin to sort of follow up on a more in-depth look at some of the challenging issues within Medicaid's role in long-term care, and especially relate that, as we discussed yesterday, to the disability focus of Medicaid. It often gets lost underneath the dual eligible debates around the demonstrations.

But in that vein, I'd like to share with Trish and other Commission members our real happiness with the materials that are being pulled together to really follow the financial demonstration models under the dual eligible demonstrations. And I think since that's a changing issue, that it's not static, that we would like to have that on the Website so that it can be updated as every state changes.

But I think it will be a real resource to the policy community, and especially to staff on the Hill who I know are constantly asking kind of where these demos are and what they're doing.

And we had talked at one point about having Melanie Bella from running that project to come in and talk with us and we might see over the next few meetings whether there's an opportunity for her to come in and update us, but I want to compliment the staff on the excellent work they've been doing on monitoring those pretty complex demonstrations.

Are there other issues that Commission members would like to raise that we should be putting on our

agenda going forward? Patty.

COMMISSIONER GABOW: I would like to make sure we have on our agenda the DSH payment cuts that are coming forth because -- particularly in non-expansion states. The cuts in disproportionate share payment could be so destabilizing to the safety net that access for the people we represent would be greatly impaired. And since those cuts are already in the financing plan, I think it's very important that we address this in a timely manner.

The other thing I would just say is, I'd like to congratulate the staff on not only their good work, but their willingness to listen to our numerous suggestions or changes with openness and great attitude. It's much appreciated by those of us who have so many opinions.

CHAIR ROWLAND: Hear, hear. Norma.

COMMISSIONER MARTINEZ ROGERS: I would like to, at Some point, see if we could bring some of the consumer advocate groups in to talk to us in relation to what they are experiencing with either Medicaid or CHIP programs.

CHAIR ROWLAND: Okay.

DR. SCHWARTZ: The one thing I can just give a little preview on is, we've been doing some focus groups to look at the experience of people who are newly-eligible, their experience in signing up for Medicaid through the exchanges. We've done one focus group so far, we have two more next week, and in January we're planning to bring some information to you which relates to that.

COMMISSIONER MARTINEZ ROGERS: That will fulfill it. Thank you very much.

CHAIR ROWLAND: Robin and then Richard.

COMMISSIONER SMITH: I think the Children's Hospital Association is doing some really interesting digging into how the medically complex, chronically ill, developmentally disabled children, and I'd love to look at that some more. I think they're working with the Hill, also, so it's a very exciting opportunity for us.

CHAIR ROWLAND: Okay. Richard.

COMMISSIONER CHAMBERS: I'd like to echo Norma's comment. It would be good to hear from some advocacy groups, you know, going into the new year, but next time we meet in January, we'll have had the implementation of ACA, one of the biggest changes in health care history in this country. So it certainly would be good to continue to stay on top of just developments as far as informing us.

You know, one thing is, I was looking at statistics last night for California's progress so far of enrollment, and the numbers are just a little shy of 300,000. I was surprised that the numbers for Medicaid enrollment was about 190,000. It was about 110,000 on the exchange side.

And I've read some articles recently having to do with some concerns of whether some enrollments on state exchanges are actually -- folks are being indicated that they're eligible for Medicaid when their incomes are unusually high, and probably it may be just glitches in systems, but certainly, as our responsibility with program integrity and making sure on the program integrity side, but also is just making sure people get aligned with the coverage that they need and they don't end up getting into a situation where they're later found to be ineligible and then they're ineligible to sign up for something else. I just wanted to make sure those implementation issues are real critical for our program going forward.

CHAIR ROWLAND: It might also be useful to ask some of the Medicaid directors to come in or to

at least provide for the record what they think we should be looking at with regard to the implementation of the ACA and what their experience has been, because I think I read in a comparable article that NaMed [phonetic] was doing some kind of a survey or contacting the Medicaid directors to find out to what extent they were experiencing these glitches in eligibility determinations.

COMMISSIONER CHAMBERS: Could I just add, just to echo Patty's comment about thanks to staff and all their great work and to Anne, as Executive Director. It's an amazing accomplishment of what we've been able to produce as far as a Commission. Thanks to all of them and their perseverance of sticking with us through all of our suggestions. So thanks.

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: I just want to remind the Commission that we agreed to do a chapter on population and public health for the June report, and Amy apparently has been assigned to work on this, so I look forward to working with her and seeing what we can do to kind of raise public awareness of what an important tool Medicaid and CHIP are to population health and all the collaborations we can do with public health.

And lastly, I want to just make a comment and that is that -- well, maybe I'll wait until we get the other comments. I just want to ask Anne to share with us her efforts to work on the Hill prior to our discussion of these recommendations. She shared them with key staffers and I think it would be helpful for us to hear what her response was. But maybe we need to continue the agenda items first.

CHAIR ROWLAND: Do you want to respond?

DR. SCHWARTZ: I was just sharing with David what I do before every meeting is I talk with all the

key staffers in our authorizing committees, and in this case, I went over the whole list of proposed recommendations, which obviously is not the final list which you just agreed to, and at that time, I went through the proposed rationale, the CBO cost estimates.

We got interest. We did not get any red flags or anybody particularly raising objections to one thing or the other. Of course, I'll now go back and give them an update on where they are, because there will be this length of time between when the report actually comes out and now. But there's folks from the press here covering the meeting today, so this is sort of news now and I'll be sure to go back and follow up with our Hill staffers so they know exactly what happened here today.

We had good conversations. I would say I generally always have good conversations and we have very open lines of communication.

CHAIR ROWLAND: And how soon are the transcripts of this meeting posted on our Website?

DR. SCHWARTZ: Generally it takes us until Thursday or Friday of next week to get them up. We get them, we look over them to make sure there are no errors, but we don't otherwise try to correct the transcript, and then there's a little bit of cleaning up that has to happen just in the format. But it will be within a week.

CHAIR ROWLAND: But it means that these recommendations that we've just voted on will be available for anyone to see on the Website in advance of the published book coming out in March?

DR. SCHWARTZ: Yes, yes.

CHAIR ROWLAND: Sara and then Sharon.

COMMISSIONER ROSENBAUM: Just to follow up on David's point about the public health

chapter, I think one of the things that would be of most interest to us, and it sort of brings two things together, is the amount of system transformation, meaning clinical and financial integration that's going on where actually public health agencies are at the table.

So in some communities, we are beginning to see public health be part of the design of one form or another of integrated delivery system, whether it ends up holding a managed care contract, whether it's an ASO, whether it's a network of health homes, going back to yesterday's discussion and all the variations we have on clinical and financial integration at this point.

But I think there are some places where you're beginning to see this crossover and it's obviously most likely to occur in communities that are very medically under-served and where the burden of poor health is the greatest. It would be great for David's theme to somehow be worked into our work on managed care. I think this is very promising.

And one of the other areas where there might be some interesting crossovers is our work on managed care and what's going on through the CDC with community transformation grants, where you see the same kind of efforts to sort of organize communities around population health issues and intersecting with health care in many places.

CHAIR ROWLAND: I have Sharon and then Patty.

COMMISSIONER CARTE: I just wanted to confirm that our upcoming agenda will include some of the longer term issues for CHIP that Chris talked about.

CHAIR ROWLAND: Right. Definitely. Patty.

COMMISSIONER GABOW: Just to add to Sara, I think that the other place where integration of

public health could occur and probably should be considered in the chapter is that if you look at institutions like Denver Health, public health has been part of the system for, I don't know, almost a hundred years, and San Francisco now has done that integration. Cambridge has that integration. And the safety net is a very logical place to do that.

And when you do that, the gender health has one of those community transformation grants, so you can link school-based clinics and community health centers and the public health department.

So I think looking at these -- and they're the major providers of Medicaid in the safety net in these communities often. So this link between the safety net integrated systems of care and public health really become an important nexus. So I think that should be part of the focus about these communities that have managed a great, true integration of population and personal health.

VICE CHAIR SUNDWALL: The last comment I'll make on this is just that the relation to Medicaid is real in that to the extent these public health initiatives work, the burden of illness is lightened and the costs to Medicaid are reduced. So it's not just a nice thing to do. It's a practical economic benefit.

COMMISSIONER RILEY: I would echo the comments of the staff. I think it's the level of work and the complexity and the deep dive into how to make Medicaid work in this new world order. It's not sexy stuff. It's terribly important stuff, and I think the work has been great.

I'd also suggest as an area of some -- as we think about public health, that's almost a luxury for the people in non-expansion states who don't have the basic coverage. So I would encourage us to find ways in our agenda to look at what's happening in non-expansion states, both as we talk about the glitches but also what happens to the poorest of the poor in those states that aren't expanding, since access is such a

fundamental mission of our Commission.

CHAIR ROWLAND: And I'd sort of build on that, too, because I think going back to the safety net issues, I mean, so many of the Medicaid population depend on the safety net facilities, and what happens in expansion versus non-expansion states there is also a very important issue.

And then since Trish didn't mention it, I think we all have talked about wanting to look better or more at how to make the administrative function of Medicaid be more sufficient and what capacities and capabilities need to be there. And I think Anne said we were having a panel on that at our January meeting.

EXECUTIVE DIRECTOR SCHWARTZ: Yes.

CHAIR ROWLAND: In fact, do you want to just quickly highlight what we might expect in January so we know what to anticipate as our New Year's present?

EXECUTIVE DIRECTOR SCHWARTZ: I was just thinking, I need to come over and see you, Diane, and go over this agenda, see if we can fit all these things in in January. You may be staying for quite a long time.

[Laughter.]

CHAIR ROWLAND: I just hope we have a warmer room.

EXECUTIVE DIRECTOR SCHWARTZ: Yes.

VICE CHAIR SUNDWALL: What's the date of the meeting in January?

EXECUTIVE DIRECTOR SCHWARTZ: January 22nd and 23rd, 23rd and 24th, whatever the Thursday and Friday are of that week after the Martin Luther King holiday. I have it written down somewhere here, and it seems to have disappeared. 23rd? Okay, 23rd and 24th, Thursday and Friday again.

Okay. These are some of the things that we've been talking about doing for January, and what I haven't done is completely scoped out the timing for this and whether it's actually possible to get all of this in in two days.

On administrative capacity, we talked about having sort of a one-two punch with -- there's been a recent study done by Trish and her colleagues at the University of Southern Maine on administrative capacity and having a presentation on that study, and followed by a panel of Medicaid Directors to talk about their perspective on the issue from sort of a very real on-the-ground.

As I just mentioned, a report from the --

CHAIR ROWLAND: But I thought that Medicaid Directors were involved in the --

EXECUTIVE DIRECTOR SCHWARTZ: Yes.

CHAIR ROWLAND: So maybe that could be a single panel instead of two.

EXECUTIVE DIRECTOR SCHWARTZ: Okay.

CHAIR ROWLAND: You might just think about it.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. As I just mentioned, a report on the focus groups that we're doing on the enrollment experience, and having been to one of those focus groups, it was really fascinating, so I hope that -- I think that will be really interesting.

As Moira mentioned yesterday, staff had gone on four different site visits to different states that are implementing what we've been called "advance payment models." We're doing that work with SHADAC out of the University of Minnesota and having them come and co-present with our staff to talk about some of these -- both the specifics of what's going on in those states but also sort of the cross-cutting themes of that.

And I think that feeds into our work in a number of different places.

We had talked about -- oh, yes, both the GAO and a joint effort by NASHP and researchers at Georgetown Center for Children and Families doing studies on comparing benefits in CHIP with those in the exchange plans, and we have some calls set up for them to come to jointly present -- you know, to present their findings of their two separate studies for your consideration.

CHAIR ROWLAND: Is the GAO study expected to be out by then?

EXECUTIVE DIRECTOR SCHWARTZ: It's done. It's sitting in a 30-day hold, so our understanding is, yes, that it will be out.

We will finish off the work for the March report by bringing you some highlights from MACStats.

We would like to present our analysis, the work we've been doing on validating encounter data to give you a sense -- Moira alluded to that yesterday, but we would like to actually talk with you about what we've done. I would guess that would be a short-ish session, but it does potentially open up a lot more possibilities for us.

CHAIR ROWLAND: Nothing is short with us.

EXECUTIVE DIRECTOR SCHWARTZ: So those are the list of things that I had on mine going into today, so I'm not going to reiterate all the things you just asked for.

CHAIR ROWLAND: But I think that gives us a sense of kind of how we're starting --

EXECUTIVE DIRECTOR SCHWARTZ: Oh, one more. We've been talking also about doing some kind of panel or invited speakers related to population health. We already had the two folks from Washington State, the Medicaid Director and the Health Department Director, some months ago. So we

would follow up with maybe a different slice on that issue.

COMMISSIONER GABOW: On that issue, to tee off of what Sara said, you might want to get someone from the CDC who's running these community transformation grants, because I think they are really a powerful tool for moving into population health.

VICE CHAIR SUNDWALL: I think we should get Judy Monroe, who's kind of the director of -- she's kind of the assistant director for OSTLTS. I never know what that means, but it's like public health and --

COMMISSIONER ROSENBAUM: State, Local, Territorial, and Tribal --

VICE CHAIR SUNDWALL: Yeah, it's the craziest acronym. It's OSTLTS or something. But, anyway, she'd be good. She's the one working with us on the ASTHO collaborative to promote the integration of the IOM report on public health and primary care, but she could talk about the community grants.

CHAIR ROWLAND: That's great.

COMMISSIONER COHEN: Maybe one angle of this is to sort of do like something on cost-effectiveness and prevention and sort of like some -- you know, just sort of looking at benefits. That's not quite as broad as some other topics that would be great to go into, but that is one way to get into this.

EXECUTIVE DIRECTOR SCHWARTZ: Yes, this topic has many, many dimensions to it, so I think we'll have to do sort of the next cut, and then I'm sure there will be multiple next opportunities after that. So we'll try and figure out what sort of -- who's available and what's the best way to roll out the next step, and then I'm sure we'll have lots of time to keep talking about it.

CHAIR ROWLAND: But we've essentially given you most of the feedback we're to give you on the March report.

EXECUTIVE DIRECTOR SCHWARTZ: Yes. Yay. Thank you so much.

CHAIR ROWLAND: I think that's a yay. You wanted that. That was your goal, and so I think we --

EXECUTIVE DIRECTOR SCHWARTZ: And thank you for achieving that.

CHAIR ROWLAND: We've achieved that today. I think we've obviously got a lot of other things that we all want to put on the agenda, but certainly we want to thank Anne and the staff for just putting together such excellent materials so that it actually wasn't that hard for us to get through all of this material today and yesterday. But it has been just really great.

And I hope that this list we've just gone over doesn't mean that the holidays are not --

PARTICIPANT: Merry.

CHAIR ROWLAND: Merry.

[Laughter.]

CHAIR ROWLAND: And our times when people have to go above and beyond, but you do always go above and beyond, and so we want to thank you and really wish all of the staff a very happy holiday, and obviously wish that to all of us as Commission members before the New Year.

And if any of the public wants to come up and ask us or give us any comments on the actions we've taken today or should be taking in the future, we welcome that.

PUBLIC COMMENT

* MR. MORGAN: Hi, good morning. My name is Simon Morgan. I'm with the Marwood Group. I just had a couple of things.

First, on DSH, just so you know, the budget deal and the subsequent three-month doc fix includes a two-year suspension of DSH cuts, so the $500 million in '14 and $600 million in '15 -- the $600 million gets tacked onto 2016 as a $1.2 billion cut, and then back-ended in 2023, there's another $500 million cut.

And, second, on your second pregnancy-related minimum essential coverage, the IRS already released their final rule on that, stating that pregnancy coverage for Medicaid is not minimum essential coverage. That came out this year.

Okay. You just sort of repeated in your -- in the wording it says, "Department of Treasury as well as HHS."

CHAIR ROWLAND: Right.

MR. MORGAN: That's all. Thank you.

CHAIR ROWLAND: Thank you.

MS. STERNTHAL: Hi, there. I'm Michelle Sternthal with the March of Dimes. I am obviously delighted to hear about the recommendations regarding the complex issue of pregnant women. Maybe I missed something, but I just wanted to reiterate that we know that penalties are waived in 2014, but I wonder if the Commission would consider making some sort of recommendation of waiving penalties about pregnant women who are on pregnancy-related coverage that is not considered MEC and that are not eligible for qualified health plans, those below 100 percent of the poverty level, or those who for whatever reason are not

in the qualified health plans, to make sure that they don't get subject to penalties post 2014, because the rule had mentioned 2014 and didn't specify beyond that.

And then one other issue is there have been conversations about Medicaid, but there are also incredibly complex issues for pregnant women who receive some sort of coverage under CHIP, namely, the unborn child option, which because the coverage is considered to be covering the fetus and not the pregnant woman, she's not considered to have minimum essential coverage if she had it. However, my understanding is if she tries to get coverage through the marketplace, the fetus is no longer considered eligible for the unborn child option because there is a viable option of coverage through the marketplace.

So it's a tangle, it's a mess, and because it affects fewer pregnant women, there has been less thought about it. But I just want to make sure even a nudge to HHS to clarify what the rules are for these women is critically important.

Finally, just a plug to talk about CHIP quality provisions. It's another area of potential exploration, especially with these provisions expiring. Now having some sort of investigation or study about the critical importance, or lack thereof, depending on what you find, regarding the quality, the CHIP quality core set, the demonstration programs, the centers of excellence and their value I think would be very useful.

So thank you so much.

CHAIR ROWLAND: Thank you.

Any other comments? Comments from Commissioners?

VICE CHAIR SUNDWALL: Before we go, I just want to again compliment the staff for their hard work on putting out this duals book. I love this memo with the MedPAC and the MACPAC logos together

and Anne and Mark just hand in hand doing good work. So this is really good. Thank you.

CHAIR ROWLAND: Okay. Happy holidays, and we will stand adjourned until 2014, and by then it will be after January 1st.

* [Whereupon, at 10:59 a.m., the meeting was adjourned.]