MACPAC

Medicaid and CHIP Payment and Access Commission

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PUBLIC MEETING

Hall of States
National Guard Association of the United States
One Massachusetts Avenue, NW
Washington, DC 20001

Thursday, September 18, 2014
9:45 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
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ANDREA COHEN, JD
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AGENDA PAGE

P R O C E E D I N G S [9:45 a.m.]

* CHAIR ROWLAND: For Commission members, we've been asked to make sure you have the mics close to you when you speak so that they can pick up all of your words and wisdom.

WELCOME AND OVERVIEW OF MACPAC WORK PLAN FOR 2014-2015

Chair Rowland. Okay. If we could please convene for this meeting of the Medicaid and CHIP Payment and Access Commission. We're glad to be back together to begin the work for the coming year. This is going to be a challenging year in terms of the many issues that the Commission is going to take up.

You see today that we continue our discussion on the future of CHIP. This is obviously a very timely issue where we are trying to look at what some of the issues and options are for the continuation of CHIP but, more importantly, for assuring that the children who have received their care through CHIP are able to continue to receive and have access to affordable and quality care through the future. So we're going to be looking -- beginning today, another round of looking at the many options that there are, the role of CHIP, the glitches that occur in trying to transition CHIP children to additional coverage, and some of the recent state experiences with moving children from CHIP into Medicaid.

We're also going to look at what has become known as the private option, the alternatives to the direct Medicaid expansion that have taken place in several of the states. Most notably Arkansas but also New Hampshire and Iowa have been working with this. It seems to be one of the options that many states that have not yet opted to expand are considering as a way to enter into coverage for their low-income population. So we will be taking that up after lunch, and then moving on to update you on Medicaid and CHIP enrollment in 2014, and also on some of the program integrity plans that CMS is putting out as we move forward through this day.

Tomorrow we're going to be hearing the results of some of our focus groups on the early experiences of new Medicaid enrollees and then talking about the disproportionate share hospital payment

study that we've been mandated to do and are beginning to do our work on.

However, these are just a few of the things that we intend to have on our plate. We obviously will be looking at the broader ACA implementation issues. We'll be focusing on long-term services and supports and the role that Medicaid plays there and the broader issues of how to provide care for the disability population.

And as we met at the end of the year and laid out our new agenda, our agenda really is a continuation of where we have been in the past, but it is to take a deeper dive on some of the most critical issues facing the Medicaid program and the CHIP program.

I have noted the CHIP issues. Those are obviously at the top of our agenda because of the pressing need to make decisions about the future of CHIP before the funding expires at the end of fiscal year 2015.

But we're also going to be taking a deep-dive look into many of the issues related to care of the disability population and trying to look at how the Medicaid program functions with the disabled, how that influences the use of more integrated care services, the role of managed care in addressing that population, and the movement now to try and provide more home and community-based care and various alternatives of how to do that. Several of the programs that provide long-term services and supports, rebalancing and the Money Follows the person, are up for reauthorization or renewal, so we need to look at the experience with those programs.

We're also going to be looking very intensively at payment policies and how they affect access to care, on what the role of managed care is, on how the primary care payment bump has worked or not worked, as it may be, since that's up for expiration in December of this year, and many States are considering going forward with it, other states are not. So we are going to be looking at that experience.

We're also going to be trying to provide a broader-based look at the dual-eligible population

and at the movement of many states to put the dual-eligible population into managed care and to the demonstrations around that.

We've done some joint work on that with our companion MedPAC, and we'll continue to put out as we can the data and information on who is in that population, what some of their needs are, and what some of their services are.

We're also trying to really look at a new round of delivery system reforms that are going on in the states, the DSRIP waivers and how those are playing out. Are we really moving toward a different kind of payment system that rewards value instead of just paying on a claims basis? How do we really evaluate the impact of the changes going on in the delivery system? And can we give any direction to where some of these waivers are successful and others are less successful? And what can we know about them?

And, finally, we really do need to begin to think about how to connect our work on coverage to access to care, to really identify where the gaps are. We've started to do some work on the use of emergency rooms and emergency departments by the Medicaid population, and that has always been sort of a sore point of whether Medicaid beneficiaries use ER services more than others. But we really need to look at the impact of changes in the delivery system, the role of managed care, and how that's influencing whether care is available. We need to go beyond looking at primary care to some of the gaps that we know occur in specialty care and to the way in which our health benefits are structured and how the payment and the benefits affect access to care.

So we have a pretty full agenda. I think we're going to probably cover most of these issues at different points during the year, so you will see them come up on the agenda at different points as we move forward. But this is really time to get very serious about providing the kind of data and information that we've been developing.

And I would just say it's really great that after starting as a new Commission, we now have our own history, our own background on many of these issues that we can build on, so we have a foundation that we can build on now. We don't have to create anew. But I would like to say that we also have a terrific staff, and that staff really is going to shine some light on many of these issues for us today. But we're really looking forward to having the ability to go deep because of the terrific staff that Anne has put together. And I'd like to just start this meeting by having a round of applause for the staff that produces such wonderful work.

[Applause.]

CHAIR ROWLAND: And now I'm going to turn to David for any opening comments, and then we are going to dig into the future of CHIP.

* VICE CHAIR SUNDWALL: Thank you, Diane. I think you've given a very comprehensive overview of our potential agenda, all the things we have on our plate that we could be looking at.

I'm very intrigued by the rollout of the ACA. I'm glad that we're going to monitor various aspects of that. The promise that it would provide more affordable insurance for all has not been met. It has failed in that regard to a certain degree. But we want to make clear that we understand the impact of the rollout or the expansion, the non-expansion states. Coming from one of those states that is still trying to decide are we going to expand or not, the governor has got a proposal seeking a waiver from CMS, and he will have to get legislative approval, but for a plan not unlike Arkansas' where we would use public funds to help purchase private insurance for those beneficiaries. So it is an interesting time, to be sure.

I also just want to point out that there are multiple proposals for Medicaid reform, writ large, and while they're all intriguing and I think they're motivated by frustration with the complexity and costs of this program, I think the work of the Commission is essential because, as we consider alternatives, let's

pretend that the Republicans are in charge of the Senate next year, and if, in fact, some of these reform proposals really are taken seriously, I'm confident that they would be informed by the work of this Commission and not just political ideology.

So it's a fun time to be involved in this, and I look forward to our meetings the next two days.

CHAIR ROWLAND: Okay. Mary Ellen, Chris.

We're going to turn now to begin what will be a broad-ranging discussion this morning with regard to the future of CHIP. Mary Ellen is going to start us off, and I know we're going to have various other staff come up to present different aspects of this part. You are now at Tab 2 of your book.

SESSION 1:

THE FUTURE OF CHIP

SESSION 1A:

OVERVIEW OF CHIP ANALYSIS PLAN

* MS. STAHLMAN: Thanks, Diane. We have a full morning of CHIP for you today, and Chris and I are happy to get the conversation kicked off this morning by reviewing recent Commission work on CHIP and children's coverage, the current status of CHIP, the key policy questions we're all going to be grappling with this year going forward, a brief overview of the CHIP analysis plan for the Commission for 2014-2015, and leave you with a snapshot of the CHIP program and key enrollee characteristics.

So just to remind you, in the March report to Congress, we focused on improving the current CHIP program, and we examined the intersections between CHIP and other sources of coverage, including Medicaid and exchange coverage. And in that report you recommended that the Congress eliminate CHIP waiting periods and eliminate CHIP premiums for families with incomes less than 150 percent of the federal poverty line.

In June, you moved on and focused on the longer-term issues around the future of CHIP, and as you recall, we examined some of the eligibility issues: in the absence of CHIP, what sources of coverage would be available to people in the CHIP income range, including perhaps Medicaid, employer-sponsored insurance, or exchange coverage, or for some perhaps uninsurance. And we examined issues around benefits and affordability, including premiums and cost sharing. We touched upon network adequacy, and we examined the financing implications for both states and the federal government.

Throughout the course of that work, the Commission came to the conclusion that there were some issues that needed to be addressed before CHIP financing runs out and particularly around affordability and the adequacy of the benefit package. And as a result, the Commission recommended that the Congress extend federal CHIP funding for a transition period of two additional years, during which time the key issues regarding the affordability and adequacy of children's coverage can be addressed.

And at the same time, you mentioned in the report and you underscored that while you were confident that the Congress could act in that time period, if such action did not happen, you would want to revisit the length of that transition period.

So what's the current status of CHIP? FY2015 is just around the corner, and final CHIP allotments will be distributed to states beginning October 1, 2014. And states will begin exhausting their CHIP balances in about a year.

We project currently that 18 states will begin to draw down their final funds in the first quarter and 15 in the second quarter, although those numbers could change when we get closer to those dates.

The congressional debate has begun in earnest. Senator Rockefeller introduced S. 2461 in June, and Representative Pallone introduced H.R. 5364 in August. Both of those bills extend federal

CHIP funding for four additional years, through the maintenance of effort, and make other changes to CHIP and Medicaid programs as well. And you'll see in your packets in Tab 2A there's a side-by-side of these two bills. So I won't go through it here, but the side-by-side lists all the major provisions of both of those bills, and you can easily compare and contrast them.

The chairmen and the ranking minority members of the Senate Finance Committee and the Energy and Commerce Committee have reached out to the governors to ask them their opinion on the future of CHIP and what their advice to the Congress is, and responses to that request are due at the end of October. So hopefully we'll have an even better indication of what the states think in this regard.

I would say timing is uncertain. Your guesses are as good as mine when the Congress will feel like it's the right time to act with advice from the states.

So key policy questions for the Commission during this analytic cycle: What sources of coverage are CHIP enrollees eligible for when CHIP funding ends? And not only what are they eligible for, but in what sources of coverage will they actually enroll? Will issues of affordability or other issues prevent them from enrolling even if they're eligible? Will some CHIP enrollees be ineligible for any source of coverage? And what policy options would minimize uninsurance for current CHIP enrollees?

What is the CHIP enrollee experience likely to be in terms of benefits, affordability of premiums and cost sharing and network adequacy? We've looked at this issue before, and it's time to delve even more carefully into it.

Are there sufficient consumer protections while the transition for CHIP enrollees to other sources of coverage occurs? And what policy options might smooth that transition?

What is the impact on state and federal budgets of the exhaustion of CHIP funding? And what policy options might exist to smooth out uneven budget effects across states?

And, finally, is there a need for ongoing coverage or coverage of certain benefits or

additional assistance with premiums or cost sharing in limited circumstances? And if so, what would the design elements of such an approach be?

So from the staff perspective, we heard what you told us last spring and at the planning retreat, and we devised an analysis plan that will roll out work over the coming months for you to consider on the future of CHIP. It clearly builds on prior Commission work. And I think at the 60,000-foot level what the analysis plan does is it looks at the folks that are currently enrolled in CHIP and says: What are they eligible for, what other sources of coverage are they eligible for? Will they enroll in those sources of coverage? And how best can we make that transition for them, help them make that transition into these other sources of coverage? What is the eligibility, the benefits, the affordability? More information for you this year, I think, on provider networks and consumer protections, an issue that we didn't touch upon as much, I think, in the last cycle, but we'll have the opportunity to do it in this cycle.

What are the state and federal financial implications of how this is all going to roll out? And what are the options for smoothing those transitions?

So today's agenda: We are going to start this morning, and Chris is going to give you an overview of and remind us all about the basic eligibility and program characteristics of CHIP and what the enrollee characteristics are. It's important to keep in mind who are these people and what they need.

There is material for you on that in Tab 2A behind the side-by-side of the two bills, and there's a series of fact sheets that describe the program at an overview level and give you some more information on enrollee characteristics.

Then we'll hear from three staff. Chris is also going to present to you a paper that's in Tab 2B on state financing issues, and the two big issues there are that the states will draw down their CHIP allotment, their final CHIP allotments at different times during FY2016; and the second issue is that there will be -- because of the way states have historically chosen design options for their CHIP program, some

states will have a higher financial burden than other states. So Chris will be presenting that this morning.

Joanne Jee, the newest member of the CHIP team, is going to be talking to you about the lessons learned from CHIP transitions that have already occurred in three states. New Hampshire and California moved separate CHIP enrollees into Medicaid. How did those transitions go? These are two very different states, one very large state and a much smaller state. And while they were going to Medicaid coverage, which looks very different than exchange coverage, what could we learn about how those transitions occurred? And were there any issues that we can learn from? She's also going to talk about Arizona, who, in addition to moving some kids into Medicaid, ended their separate CHIP program and referred those families to the exchange. What do we know about what happened to those kids when they went there? And how did that go?

And, finally, this morning you're going to hear from Veronica Daher, who's going to talk to you a little bit more about consumer protections. And although there are consumer protections in current law within the Medicaid program, if you're moving from fee-for-service to a managed care plan or moving among managed care plans, or the same with CHIP, there is a history here at the federal level; there is a history at the state level. But given the transition that could occur for these separate CHIP kids into these other sources of coverage, are those protections adequate for this type of transition? So we're going to start that conversation today.

As far as the work ahead, at the October meeting we'll come back to you with many of these same issues that we're touching upon today. Perhaps you'll be asking us for additional information. Perhaps you'll want us to be drilling down with some of the policy options and the pros and cons and more analysis for you on these issues, so we'll be coming back. But we'll be building on the agenda as well. It's going to snowball over the next few months. And so we'll be coming back to you in October with an analysis of benefits and affordability issues in exchanges. We looked at this clearly last year. At this

point, though, we have a lot more information. We have more information on what the benefits are in those exchange plans, what the cost sharing looks like, the deductibles, the premiums. And new research has come out over the summer that gives us a better sense of what that experience is going to look like, and taking into consideration the cost-sharing reductions under the Affordable Care Act. So that'll be October.

Then, we will be moving on, and hopefully later this fall, the December meeting, perhaps, we are going to look more carefully at the transition to employer-sponsored coverage and what does that coverage look like in terms of benefits and cost sharing, and to what degree will, in the absence of CHIP, people be eligible for employer-sponsored insurance, and to what degree are the premiums subsidized. So, we are looking forward to that work.

We will also be presenting to you later in this cycle work around enrollment, how many people are going to be in which coverage buckets, and we are working on this with the Urban Institute and AHRQ. They are doing some of this work with support from MACPAC. And, we will be able to get to a point where we can say how many people are estimated to go into each of those coverage buckets and how many do we anticipate will be left uninsured. I wish I had that for you today. That would be great, but research being what it is, we are doing the best we can, and with the help of our colleagues, we will bring you that as soon as it is ready.

We are also going to be looking more carefully at pediatric network adequacy, where we will be hosting a roundtable, an expert roundtable, later this fall, where we are going to be talking to plan executives and pediatricians, researchers, consumer advocates, to talk about what is unique about a pediatric networks. What are the design elements there, and what is happening on the ground now? So, we will be happy to bring some of that work back to you at the December meeting.

We are also very hopeful that the Secretary will release the much anticipated CHIP evaluation, and as soon as that happens, we will bring the essence of that report to you and see if you want

to make any comment on it.

So, it is a full agenda. At each meeting, we will be revisiting the issues from the prior meeting and returning to you with work you need, so that by the end of the cycle, you'll feel like you have the material you need to make decisions about whether you want to recommend anything to the Congress, the Secretary, or the states about the future of CHIP.

COMMISSIONER ROSENBAUM: Just one. That sounds like a great work plan, and I have one additional thought, if we could try and grapple with it. Over the next several years, of course, as you know, we are in a maintenance of effort time period, so I would be interested in knowing what the issues are for transitions that happen within the maintenance of effort time period versus transition that happen only after the maintenance of effort time period ends and so there is sort of no back door pressure, in a sense. I think we want to be sure that we flag how each of these issues plays out if it is happening within this four-year window or not.

MS. STAHLMAN: Thank you.

VICE CHAIR SUNDWALL: Mary Ellen, thank you. That is an ambitious overview. Diane said something this morning that caught my attention, and if I understand it correctly, there have been provisions to encourage Federally Qualified Health Centers to take care of more pediatric patients. Is this something in CHIP? Maybe that's another alternative to how they have traditionally gotten care. Can you explain to me what those are, or what is in place where FQHCs -- are they more pediatric-friendly? Is there something related to that --

MS. STAHLMAN: Well, we'll have to get back to you on that, David.

VICE CHAIR SUNDWALL: -- or did I misunderstand?

MS. STAHLMAN: I would be happy to look into it at the staff level and bring you back a little bit more information specifically on the FQHCs.

VICE CHAIR SUNDWALL: Because, I am familiar with the National Service Corps and, of course, Community Health Centers, but I'm wondering how many pediatricians work in those places. Is that a legitimate thing to push? Of course, there's been increased funding for the Community Health Centers and that may be another place for the poor younger kids to get care where we -- I mean, a way to incent that that they haven't before.

COMMISSIONER GABOW: To that point, I think FQHCs have been built on care primarily for women and children, and if you look at their patient population, it's heavily in the under-18 group. So, I think it is well set up, in general. Now, they don't tend to have specialty care. As FQHCs don't for adults, they tend not to have specialty care for children within the FQHC. So, as we think about network adequacy, one question I would like is to know how many of these narrow networks in subsidized premium include children's hospitals, because, generally, while they are not the only provider of high-level specialty care, they certainly are an important provider, and I think in some of the more narrow networks, they aren't included as network providers, which probably is a relevant issue.

CHAIR ROWLAND: Burt, then Sharon.

COMMISSIONER EDELSTEIN: Mary Ellen, this is a terrifically comprehensive approach, and for those of us who have a particular concern about children, it really does highlight the issues that we're concerned about.

Also, on the network adequacy endeavor, the roundtable, as you plan for it, your materials that you prepared for the Commissioners highlight a number of dental problems with access to care, network adequacy, in particular, and I'd like to make sure that the planning includes inclusion of that consideration.

MS. STAHLMAN: Not only in terms of the network adequacy, but, clearly, on the benefits side, as well, we'll be coming back to you --

COMMISSIONER CARTE: I'm glad to see, Mary Ellen, that the work ahead will have an emphasis on looking at enrollment and on insurance levels, because it was disconcerting to see that one of the lessons of the CHIP transitions from the three states we've looked at is we really don't know how many children became uninsured as a result of those transitions.

COMMISSIONER HENNING: On the first point, FQHCs, in particular, mine, look at pediatrics as one of the few places where they can really get paid, because undocumented women that have babies have U.S. citizens and, therefore, they have coverage, and that helps us subsidize care for their moms. But, I would like to see some emphasis in the 17 percent or so of women that are currently getting some subsidies from CHIP for their maternity care which will go away if CHIP goes away, and they don't have the option of buying even exchange coverage if they had the money, which they probably don't.

CHAIR ROWLAND: I think that you've obviously got a very full agenda and we clearly will be looking at many of these issues, but I'd like to also add one to the table, which is I think it would be useful to look at what the impact of eliminating the family glitch would be on the CHIP issues. If that were corrected, what would that do to the future options? So, I think that should be one of the options that we look at.

And, obviously, there are lots of financing issues, so we're going to turn to Chris to take those on.

MS. STAHLMAN: Just give me one more minute here for one more note for you -- and we look forward to, by the way, bringing you more information on the family glitch, I think at the December meeting. So, clearly on our agenda, and probably should have mentioned it.

So, we wanted to kick off this morning with a snapshot of CHIP and some key enrollee characteristics. While you all consider what the transitions will look like over the next couple of months, you need to keep -- we all need to keep in the back of our mind -- or the front of our mind, actually -- who

are these enrollees and what do they need? Who is eligible for CHIP? How many are enrolled? What is their family income and make-up? What is their health status? What is their need for health care and their access to services?

And, keeping in this mind will help, and understanding the population better will help us in exploring policy options around the benefits and affordability that better respond to these enrollee circumstances, and crafting consumer protections during the transition to new coverage sources, if it's necessary, that respond specifically to this population, and assessing the impact of policy options on enrollees, particularly those with special health care needs.

So, you're going to hear us coming back to sort of key CHIP enrollee characteristics throughout our work because we all need a reminder of it, and Chris is going to kick that off right now, first, before he gets into the financing --

COMMISSIONER GABOW: Two comments. I would hope that, at the beginning of all of this, and as we issue various reports, that the Commission can affirm quite vigorously we don't want to see the coverage of children be less than it currently is. We made such advances in covering children with CHIP. I think we want to affirm that, whatever happens, we don't go backwards to the pre-CHIP state. So, I think being clear about that affirmation would be very good.

The second comment I would make, as we talk about affordability, I think it has to be, and hopefully, we can put it in the context of what these families are paying for everything else, because, as we all know, housing is becoming more of an issue, transportation, and so what, really, do they have as flexible income? I don't know what context we're thinking about affordability, but if it's not in the broader context of what are the burdens on these families, I mean, little things like school supplies now are things that are being charged for in many schools, or to be in a sports program. So, what, really, is the burden on poor families broadly across the economic needs?

And, the other thing in terms of affordability that I think often gets overlooked is what's the burden on providers for collecting these copays, which often end up not being collected and just move into a bad debt category. So, you know, it sounds like, oh, a dollar for a prescription, isn't that a terrific idea, but is the juice really worth the squeeze, and that's often not. From the provider perspective, it adds a whole layer of administrative complexity, and also for the states for trying to collect these premiums. Is really the juice worth the squeeze? And, I think, trying to understand that in the context of affordability -- I mean, affordable to who? It's not just to the person. It's to the provider and the administrator of the program, as well. That piece of the equation often gets omitted.

* MR. PETERSON: All right. Good morning. So, now we'll go down to the 30,000-foot level from 60,000, and to begin with, a refresher of some key facts about CHIP.

As you know, eligibility and design vary across the states. Some states have chosen to implement their CHIP programs entirely as an expansion of Medicaid, and that is eight states and the five Territories. So, just for everyone to be aware, in this context, when we're talking about CHIP, when we say Medicaid expansion, we're talking about expanding the CHIP program and it has nothing to do with the Medicaid expansions of the ACA and for those adults.

In addition, there are 14 states that, as of January 1, 2014, were considered entirely separate CHIP programs. So, prior to the ACA, that really meant all of their CHIP money went for non-Medicaid expansions. But, as you know, and what we have talked about before is that the ACA made some changes, for example, with the stairstep children, so that those were six- to 18-year-olds between 100 and 133 percent of poverty who, previously, states could cover with their separate CHIP programs. The ACA requires states to increase Medicaid up to 133 percent of poverty. So, those states that had covered those kids in separate CHIP coverage had to move those kids into Medicaid coverage. Now, those are Medicaid expansion CHIP kids.

But, these states, our sense is that many of them are still going to consider themselves separate CHIP programs, even though now they do have some Medicaid expansion CHIP kids. So, that's just something to be aware of. But, states that had expanded to the stairstep kids, for example, prior to 2014, they have a mix of Medicaid expansion CHIP children and separate CHIP children, so those are the majority of states that are combination programs.

Upper income eligibility levels vary by state, 175 percent of poverty in North Dakota to 405 percent of poverty in New York. And, in 2013, there were 8.1 million children, and some of the breaks that we have that are included in MACStats, here is one that almost 90 percent of CHIP-enrolled kids are below 200 percent of poverty.

And, on the financing side, CHIP pays an enhanced matching rate relative to Medicaid, so the CHIP matching rate is 65 percent up to 81 percent. That compares to, in Medicaid, where it's 50 percent to about 73 percent.

And, when we look at spending, there was $13 billion in spending in fiscal year 2013, 70 percent of which was federal.

So, now, these are charts that our new analyst Rob Nelb put together that, I think, shows kind of an innovative way to think about where states are in terms of their eligibility levels for various children, and what it shows is as we -- I'll walk you through this one. As we start at the bottom, 50 percent of poverty, all states cover children in their Medicaid program with Medicaid dollars at 50 percent of poverty. And then, as we work up to 100 percent of poverty, it's still the case.

But, once we cross that 133 percent threshold, then things start to change and Medicaid funding is still the bulk, but then it moves toward Medicaid expansion CHIP funding versus separate CHIP coverage. And, as we move up the income scale, of course, there's less Medicaid, and finally, separate CHIP kind of peters out and exchange coverage is potentially there.

And, then, the point as we move through these other slides is that you see that Medicaid coverage becomes less prevalent and separate CHIP coverage more prevalent as we move to older children.

And, that provides, actually, a good background for these slides that follow, where we have looked at probable CHIP children. So, it's really difficult from surveys of families for them to know positively that they're in a separate CHIP program versus Medicaid, and so what we've done is we've looked at the National Survey of Children's Health and looked at families who say, yes, my child is in Medicaid or CHIP, and we've looked at the income range where separate CHIP exists in those states to say, well, it looks like these are going to be separate CHIP children.

And, what we have found in looking at these children is, compared to Medicaid children, the separate CHIP kids are older, and, of course, that's expressed in those slides we just saw, as we move up in age, separate CHIP coverage was more prevalent in more states; that separate CHIP children are higher income, not surprisingly; and, they're more likely to have two parents in the home and to have a family where there is an employed parent.

Now, when we compare these children, the probable CHIP children, to children with private insurance, we find that they're actually similar in age, but, of course, the probable CHIP children have lower income and they are less likely to live in a two-parent family or to have an employed parent.

So, that was talking about some of the socio-economic characteristics, and now we move to the health status of these children.

One of the questions that one must think about in a post-CHIP landscape is how many of these children have special health care needs, and the answer is, from what we find in this survey, is 24 percent of probable CHIP children are reported to be children with special health care needs. That is similar to Medicaid children and is higher than privately insured children, of whom 19 percent are considered to have special health care needs, and also versus 12 percent of uninsured children.

If you look at specific chronic conditions, these relationships look the same, where separate CHIP children have no significant differences in the prevalence from Medicaid children, and that probable CHIP children have significantly higher rates of these -- most of these chronic conditions compared to the privately insured.

And then when we look at utilization and health care usage for these services, probable CHIP children use more care than probable Medicaid children but less than privately insured when we are looking at medical visits, preventive medical visits, specialist visits, and any dental care.

Another way to look at access is whether families report that there is unmet need. Probable CHIP children report similar levels of unmet need as Medicaid, 5 percent for medical care, 3 percent for dental care unmet need. That is statistically significantly different from privately insured, but 5 percent and 3 percent versus 2 percent, one could contend, well, those are not really substantial differences.

It is also worth noting that families of probable CHIP children support similar levels of problems paying for medical bills as privately insured compared to probable Medicaid, which is slightly lower.

And one kind of general note on all of these numbers that we have talked about in looking at the characteristics is that when we see these differences in health status, in health care use, and in access, to keep in mind that those differences may be driven more by family income rather than the source of the coverage.

So that concludes this part of our talk.

COMMISSIONER MOORE: If you take this back up to the 60,000-foot level, Chris, would it be fair to say CHIP kids are more like Medicaid children than they are like insured children? I mean, it looks that way to me. Would you be comfortable making that kind of statement?

MR. PETERSON: I think the numbers say sometimes yes and sometimes no, because I

think sometimes the CHIP kids look like they are in between the Medicaid and the privately insured.

COMMISSIONER MOORE: Yeah.

MR. PETERSON: And so it does depend on the measure, but you're right on the access to care measures. They were similar to Medicaid, but on the specific utilization measures, they are more -- you know, there goes Medicaid, CHIP, private insurance.

I think to your point, though, is that what our previous analyses had shown is when you control for health status and you control for income, then almost all of the differences go away between Medicaid and CHIP kids versus privately insured.

COMMISSIONER MOORE: Just going back to Patty's point and thinking about it in this context, it just seems to me we need to bear in mind that we made a commitment to cover America's children, poor and needy children, 15, 18 years ago, and we want to continue that, especially given what we know about the needs of those children and their families. And I might add something about pregnant women in here, too, but I won't right now.

CHAIR ROWLAND: But you also, to go with this point, might want to look at dividing the CHIP probable population up into those that are in the lower income tier and those that are slightly higher, since I would expect that as you go up the income scale, you would be more like the privately insured and at the bottom.

MR. PETERSON: There were recent results that were put out in a Health Affairs paper using different sorts of data, and they looked at lower income children with employer-sponsored coverage. So it was kind of going at your same question in the opposite direction, and that is rather than trying to look at the CHIP children by different incomes, let's just do the comparisons to the employer-sponsored coverage by just looking at lower income kids, and there, a lot of those differences went away, as well.

CHAIR ROWLAND: Right.

MR. PETERSON: So that kind of illustrates that same point with another source.

CHAIR ROWLAND: Andy and then Burt and then Sara. Burt.

COMMISSIONER EDELSTEIN: I believe this was the National Survey of Children's Health, primarily, this analysis.

One of the things that you had in the materials that you prepared for us but wasn't on Slide 17 is a figure that I wanted to highlight for the Commissioners, and that is, the percentage of parents reporting that their child had an oral health problem in the past 12 months was one in four, 25 percent of kids. The fact that the unmet need is reported at 3 percent suggests that these kids are getting tremendous care, and my separate analysis of the National Survey of Children's Health does not show that differential.

So either there is a question about how the analysis was done or there is something magical happening that this 25 percent of kids with problems are getting them all taken care of. But it certainly is an eye-popping number, relative to all other problems that kids have.

The analysis that I just completed of the National Survey of Children's Health, I believe -- and I will get it during a break and get the exact figure, but I believe it was 70 percent of the unmet need reported by parents in the National Survey of Children's Health for kids in Medicaid and CHIP was dental.

CHAIR ROWLAND: Okay. Sara?

COMMISSIONER ROSENBAUM: I have a question, sort of a terminology question, your presentation, which was great, reminded me of.

So we talk about comparing CHIP children and privately insured children. It is my understanding that there are a number of different ways that states achieve CHIP coverage. They might do so, obviously, by expanding Medicaid, and then those children are enrolled in a Medicaid Managed Care plan, typically. They might act as their own direct insurer, like a state single-payer program and pay their doctors as an insurer would, or they buy a private insurance policy for children. And I think this becomes

highly relevant because this is where the -- and it goes back to Diane's point earlier about the family glitch issue.

At some point, I think we need to get a better fix than we all have on exactly how states are effectuating coverage today, because if we are finding that a lot of states are in fact effectuating coverage by running a premium support system that is much more generous on cost sharing and much more generous on premium assistance, makes accommodations to children that are kinder than currently is the case in the exchanges, I think trying to figure out how to move between the two sources of subsidization becomes a very different matter from trying to figure out how to move when we have children, say, in a separately state-administered program but that's run like a state insurance program, with the state as the payer and the sponsor.

So I'm asked this question frequently, and I'm never sure how to answer it, but I think that the experience of transitioning, whenever it happens -- maybe it never will happen, but whenever it happens, it's going to be a different experience. And I assume that in the three state case studies we've got on deck, maybe we'll also be able to talk about this a little bit, because there are things you would do if you were moving from one premium support system to another that would make life a heck of a lot easier for families, putting aside the cost sharing and the scope of benefits, versus things that you would have to do if you were dealing with essentially an older type of program.

COMMISSIONER EDELSTEIN: Yeah. I apologize. This is a non-sequitur from Sara's comment, but I just realized that I stated the statistic in the inverse. It's about a third of the kids for whom unmet need is dental, not the 70 percent. It's the 30 percent. For public record, I want to be sure to correct that.

COMMISSIONER GABOW: Can I ask a question about the fact that Judy said you roughly agree that there is not much difference between -- generally speaking, between the Medicaid and the

CHIP kids? My understanding -- and correct me if I am wrong -- is that EPSDT is not mandated in CHIP as it is in Medicaid. So what is the implication of not having EPSDT in CHIP in terms of outcome or care? It would be very interesting to me if not having EPSDT had little impact on the outcome or health status of kids who are in the CHIP program. That is one question.

The second thing is I think it's surprising that the uninsured have less children with special needs and less children with chronic conditions than the kids in Medicaid or CHIP. Now, is that because once you are uninsured -- once you have a chronic condition or special needs, you actually somehow get rapidly into one of those forms of coverage?

COMMISSIONER ROSENBAUM: You can enroll at any time in either of those programs.

COMMISSIONER GABOW: Right. But that means they are, I guess, and so it is sort of surprising, in some ways. I guess it is an impetus. The hypothesis is that it becomes an impetus to find a program and enroll, but still you have 12 percent who don't have impetus, despite the problems, so peeling that onion a little bit by being of interest in terms of understanding of things that lead to enrollment but facilitate enrollment.

CHAIR ROWLAND: Well, obviously, in that, we also have to take immigration status into effect, as well.

Andy?

COMMISSIONER COHEN: When I was listening to the presentation, Chris, something sort of jumped out at me that was sort of different from what I had understood or the conventional wisdom that I had understood that the experience of kids in CHIP, like their utilization is substantially lower than kids in Medicaid in general, and looking at doing the methodology that you used -- and again, I may very well be speaking from a one-state experience. The methodology that you looked at, what you call

"probable CHIP kids," you are just saying higher income. You are saying higher income kids. Kids that are above the Medicaid income eligibility level, you are calling "probable CHIP kids," and I was trying to sort of reconcile these sort of two things.

And I think it's probably fair to say, just like, Patty, you were describing, that in a family that has a kid with a special need, there is a special push to get coverage.

Similarly -- and some states, I think, make this more available than others -- for a kid who is maybe at a borderline income level or even over income, if the kid has a significant health need, you can use a medically needy eligibility or some other eligibility way to get into Medicaid. And I don't think that is available in all states, but it is certainly available in some. So I just wanted to sort of ask you whether you think this, both logic and empirically, is correct, because I think that if you actually looked at the utilization experience of kids in CHIP and Medicaid, it might look a little bit different than if you looked at the income levels. And that may be because there are a few states that have some -- or maybe many states that have some ways of getting sicker kids into Medicaid by using other eligibility pathways. Is that right? And that may not always be.

MR. PETERSON: So, first of all, just to clarify, we are looking -- the probable CHIP children are those who are in the income range for separate CHIP in that state.

COMMISSIONER COHEN: Right.

MR. PETERSON: So you are correct. They are going to be higher income on average than Medicaid children.

Now, having said that, let's move to the second question, and I think what you are observing is kind of what I was hinting at in my last bullet, and that is, when we are comparing Medicaid kids and CHIP kids and privately insured kids, we're seeing kind of two opposing effects. One is income. So what we would expect in advance is higher income kids, there aren't the financial barriers to obtaining care, so

they're more likely to get care. So that would make the privately insured kids and the separate CHIP kids be more likely to get care.

On the other hand, the Medicaid kids are sicker when we look at many measures. So that's where you kind of get different stories, and it may not line up with what you're thinking because the impact of higher income in terms of accessing care or utilizing care appears to outweigh what might happen in terms of the Medicaid kids being sicker. So that, I think, is -- once we would control for a lot of those things, those differences may go away or not be the same.

SESSION 1B:

CHIP FINANCING: STATE BUDGET IMPLICATIONS

* MR. PETERSON: So now we're going to go down to about the 10,000-foot level, I guess, or maybe even lower, and talk about CHIP financing, in particular on the state budget implications. There's a lot of material that was put into this memo, and there's a lot of material that is in this presentation, so I'm going to begin with the key points so you know what message we're trying to give. And as we go through the details, you'll be thinking, okay, this is why he's telling me this.

Then we'll talk about the source of data for the projections we're using. I'll provide a brief overview of federal CHIP funding. We'll talk about the projected exhaustion of federal CHIP funding in fiscal year 2016 under current law. And then we'll talk about the state budgetary effects of CHIP's exhaustion from six groups of CHIP enrollees.

So heretofore we've had kind of a broader view and broadly just characterized everybody in CHIP as either Medicaid expansion or separate CHIP. There are some other groups, and they make up a much smaller percentage of spending, but now that we're getting more into depth, we need to cover the waterfront. And then we'll end by talking about possible next steps for analyses and exploration of options, and so we're hopeful that the presentation here today will spur in your minds some options that

kind of bubble up for you and that we should look into some more.

So under current law, states will begin running out of federal CHIP funds in October 2015. That's when some states will begin to run out. State budget implications of CHIP's exhaustion will depend on their spending levels for six groups of CHIP enrollees and, thus, the budget implications on states are uneven across states. So we've got the Medicaid expansion children. They account for 50 percent of CHIP spending, and states must continue Medicaid coverage for those children at least through 2019 at Medicaid's lower match. So what that means is these states continue to be on the hook, but they're on the hook for spending more of their own money to accomplish this.

Then the next groups are separate CHIP children, unborn and those 0 to 18, as well as pregnant women. They account for 43 percent of CHIP spending. When the federal CHIP money runs out, states are relieved of any further budget obligations for those children.

Now, a separate conversation we want to have is: What happens to those children? Do they get employer-sponsored coverage? Are they eligible for exchange coverage? Will they take it up? But for this presentation, the focus is on what happens to the states? What are the obligations?

And then to finish it off, we have 2105(g) states and the territories. They account for only 2 percent of CHIP spending. And we'll talk about these groups in more detail. But essentially they use CHIP funding to cover children who are enrolled in Medicaid, and they get supplemental CHIP funding for certain children.

The projections that I'm using in this presentation and that were used in the memo were based on the Form CMS-37. States provide quarterly projections to CMS of their CHIP and Medicaid spending. And at the time the memo was crafted, the latest that we had was from May 2014. So what states provided at that time was their projected 2014 spending and their 2015 spending. For us to get to 2016, we assumed that growth increased by 5 percent above the 2015 levels, which is consistent with

historical trends. And, in fact, we assumed that the CHIP matching rate stays the same -- except, of course, there is the 23 percentage point increase that takes place in 2016, but we're just building that off of the 2015 level.

In November, we're going to have different numbers because we will have states' final 2014 CHIP spending and we will have their own projections of what they will spend for 2015 and 2016 if the program were fully funded. So things may change.

As a recap of federal CHIP funding, states are provided capped federal allotments every year based on their recent CHIP spending, and -- this is important -- states have two years to spend their allotments. So that means in any given year states have their own leftover funds from last year to spend as well as their current year allotment.

Then if a state is going to exhaust those funds, there are other funds that may be available. Number one is the contingency funds, which is primarily based on increased CHIP enrollment in 2007 if you qualify. And if that doesn't cover the shortfall, then there are redistribution funds available. So from other states that did not spend their allotment after two years, that money becomes another pot that's available to plug shortfalls. And this essentially really has not been necessary except in one case since 2009 based on the way that CHIPRA, the law that provided continued CHIP funding, changed the allotment formula.

So the current law scenario for CHIP in 2016 is as follows then: On October 1, 2015, which is when states usually would get their new allotment, there is no new allotment. States can use their leftover FY2015 balances. At the same time, the federal CHIP matching rate increases by 23 percentage points, so it goes from 88 -- it will then range from 88 to 100 percent rather than the current 65 to 82 percent.

CHIP's authorization continues; however, those contingency funds are no longer authorized

in 2016. So that goes away as a possible fallback for funding. There will be redistribution funds available, and that will delay states' exhaustion of CHIP funds by a week or so. So it's not much money spread out across a lot of states. It doesn't last long.

For the visual learners, this is that, those same slides. So if we start on the left-hand side with fiscal year 2014 in the blue, states get their fiscal year 2014 allotment, $9.4 billion, and then they have 5.5 of their prior year allotment that they roll over, apply it against about $10 billion in federal CHIP spending. So this indicates there appears to be plenty of money in the system nationally.

The same story for 2015. They have their current year 2015 allotment. They have leftover from the prior year against the $10.8 billion in spending.

2016 is different. There is no blue bar. There is no 2016 allotment. But states have 2015 allotments to draw from. That is against $15 billion in projected federal spending. Why is that number so much higher? It's because of that 23 percentage point bump in the federal matching rate.

So what this means is that states are going to run out of their CHIP funds in 2016 at various points during the year. Eighteen will run out, according to the current projections, in the first quarter, and you see how that plays out. The majority will run out in the first half of the year. According to the projections we had, two states would actually have funding to last through the entirety of 2016, although we know in one case that they had understated their projected spending, and that will not be the case. And that may also be the case with the other state, but we have not had a chance to follow up with them.

So how does this play out in terms of the six CHIP enrollee groups that I mentioned beforehand? Half of CHIP spending is for Medicaid expansion CHIP children. Then you've got another 36 percent that's for the separate CHIP children age 0 to 18; 7 percent are these unborn children. The pregnant women make up 0.2 percent of the total, so obviously quite small. 2105(g) we'll talk about in a little bit in more detail, but also quite small, although important to that handful of states that receive those

funds.

To round it out for states, 5 percent of federal CHIP spending is for state program administration of CHIP, and then territories round out the pie chart.

So now let's dig into each of these groups individually. Again, when federal CHIP funds are exhausted, states fall back to the Medicaid matching rate for the Medicaid expansion CHIP children. So we've usually been looking at the federal matching rate, but let's flip it around and look at it from the state perspective.

In 2015, the states' share of CHIP is -- the median is 29 percent. Once the 23 percentage point increase takes place, then the states have to pay 23 percentage points less, so it's 6 percent.

Falling back to Medicaid, the median state share is 42 percent. So what that means is that these states for their Medicaid expansion CHIP kids would be paying 43 percent more for their coverage without CHIP. And, generally, states are subject to the ACA's maintenance-of-effort requirement, so their coverage, states must continue that coverage through at least 2019. And to Sara's earlier point, there are still mandatory populations who are under 138 percent of poverty who are in Medicaid, these stair-step children, for example, that even once the MOE expires, states are still on the hook for that in perpetuity. So this has a big impact for states and on their budgets. But it varies by state.

What this shows you is the percentage of spending that states have attributed to Medicaid expansion CHIP children. On the far left-hand side are those with less than 10 percent of their spending from Medicaid expansion CHIP children, versus on the far right-hand side, these are the states who are primarily Medicaid expansion states who, if CHIP funding runs out, these states are on the hook for the difference between the CHIP matching rate and the Medicaid matching rate.

So, on the one hand, those children, they're not going to lose coverage. They're going to continue in Medicaid coverage. The impact is on the states and how much more they have to pay for

covering those children.

So now looking at the separate CHIP children age 0 to 18, again, 14 states are considered entirely separate CHIP with 29 considered combination. When federal CHIP funding is exhausted, states have no further budget obligations to those separate CHIP children. In the absence of CHIP, those children could end up on employer-sponsored coverage or subsidized exchange coverage, they could be uninsured. But the point for this presentation is that none of those sources require any state sharing. And because of modified adjusted gross income, it is unclear whether or not states could expand Medicaid to these children, particularly above 200 percent of poverty. In other words, even though states are relieved of their responsibility and these children go potentially to other sources of coverage or not, one question is: Could states at their own option say, well, we still want to cover these children and could we expand Medicaid? And in some cases, the answer is not entirely clear. But the point being from the state budget perspective that would be their choice to the extent it is permissible.

Separate CHIP for unborn children, 15 states cover unborn children. All 15 of those states cover unborn children in the Medicaid range -- income range for pregnant women. So what that means is that those unborn children are generally to mothers who lack satisfactory immigration status. Three other states -- California, Tennessee, and Texas -- also cover unborn children above the income range for pregnant women on Medicaid. So those unborn children would have mothers who are citizens and qualified citizens as well as those lacking satisfactory immigration status.

So when federal CHIP funds are exhausted, there is no fallback, there is no federal funding that would exist currently, except perhaps for California, Tennessee, and Texas if they decided to expand Medicaid for pregnant women to those higher-income ranges, again, if that's permissible.

Three states cover pregnant women explicitly in their CHIP programs, and you see the numbers there. You'll recall it was, I think, 0.2 percent of federal CHIP spending, so not much.

Without CHIP, these women may qualify for subsidized exchange coverage. No state match in that case. It is unclear, however, because of MAGI whether states could extend Medicaid eligibility to those pregnant women if they so chose.

So one of the other groups is 2105(g). There are six states -- probably the best way to do this is to give an example. In 1997, Minnesota expanded its Medicaid program -- prior to 1997, up to 275 percent of poverty. Then CHIP came along and said we will allow you, states, to expand your Medicaid program or create a separate CHIP program, and if you do that, all those additional kids can get CHIP money. And the state said we are at 275 percent of poverty; we're not going farther -- or much farther. So I think now they cover infants between 275 and 280 percent of poverty in CHIP.

What Congress authorized these states to do is to use CHIP funds to pay the difference between the Medicaid matching rate and the CHIP matching rate for children above 133 percent of poverty. So it ends up being a small amount of money nationally, but it accounts for half of the federal CHIP spending in Connecticut, Minnesota, and Vermont. In your Commissioner materials, at the end of that memo on CHIP financing, this information is broken down in Table 1.

So without CHIP, these states would not receive the supplemental funding that they receive for Medicaid-enrolled children above 133 percent of poverty. And you can see why we've avoided trying to talk about that because it's so complicated to try to explain. But the final group is the territories. Four territories use CHIP funds to pay for the coverage of Medicaid-enrolled children once the territory's Medicaid allotments run out. So territories, unlike the states, get capped Medicaid allotments. And once those allotments run out, then they draw down their CHIP dollars for those children, and that accounts for about 1.4 percent of federal CHIP spending. So without CHIP, no other federal matching funds would be available once the territory's Medicaid allotments are exhausted.

So that is walking you through in detail those six groups. In November, states will provide

the actual CHIP expenditures for 2014 and their projections for 2015 and 2016. So considering the six groups' state budget impacts, what are the potential options for staff that we should develop for discussion later this fall? And some of the things you may want to consider are the extent to which any federal relief might be needed for states who have increased spending, particularly if it's mandatory on those states; whether such relief should be broad, for example, to hold states harmless for any population they continue to cover through Medicaid or whether it should be narrower; and, finally, whether that relief should be permanent or if it should be temporary.

Thank you.

CHAIR ROWLAND: First of all, I'd like to say that it's nice to see the territories included in our analysis. Too often we look at the 50 states and the district, and the territories get left out, though they do have a very unique set of issues due to the cap on their funding.

Second, I think that you mentioned that some states might not have the option of moving these populations into Medicaid, and it seems to me that one of the things we should be looking at is what -- how do we smooth some of those pathways? And what are the obstacles if a state elected to decide to move their population in? So I think that it's not exactly a financing issue. It's first and foremost what choices do they have for coverage of children, and then how would we finance that?

COMMISSIONER ROSENBAUM: Well, I mean, that was virtually a tour de force. I couldn't possibly have done that.

MR. PETERSON: Did you say "torture"?

[Laughter.]

COMMISSIONER ROSENBAUM: Yes, a torturous tour de force. I couldn't have written it, I couldn't have spoken it. So I was sort of feeling so underwater by the numbers, because, I mean, it's just a very complicated issue. So at some point I sort of tuned out or tuned over to something

else and tried to come at the problem from a slightly different way, just wondering what the easiest way is for us to present this issue to the world.

If we assume there was no CHIP, there had never been CHIP, but there was the Affordable Care Act and there was Medicaid, states would have covered children up to 138 percent of poverty, and then the federal government, through the subsidy system, would be picking up children above that amount, unless a state wanted to, in fact, set a higher Medicaid eligibility standard for children, and we're going to hold that question off to one side.

And so I think to me sort of the key question is if we've ended up in a situation where the benefit design -- and I'm putting in cost sharing -- is potentially better and sometimes much better in CHIP than it is in the current state of exchange coverage and we have eligibility that we don't have in the exchange, as a federal policy matter how much should we be asking states to make up for the deficit that we've created by failing to establish a federal system that is workable for children? And it seems to me that is the real policy question for Congress. How long do you take to do this? Do you take four years? Do you take two years, three years, whatever? And should we be asking states at this point to fill in for the limitations of our exchange program? And if we're going to make that request on states, then how much should we expect them to bear, especially -- you know, frankly, I look at Arizona, and I totally understand Arizona that said, "We don't want to do any of this." I mean, you were supposed to set up a federal system for giving children subsidized insurance coverage that was good, and you didn't do it, and you want us to keep paying for your failure, and we don't want to do that anymore.

I think the question of whether -- going back to Patty's observation, whether there's a slice of children who some states would say are enough like low-income children so we want to give them the extra Medicaid protection, I think is an important issue that some states may answer yes. But if you flip everything on its head, we are basically trying to figure out here which states are in which boats for the

failures or the failings of the federal system. And how do we ease this situation for them? And I think that's a very different question for us to try and answer for Congress from just the question of what do we do about the CHIP maintenance of effort.

I put this out there only because I'm thinking a lot about this from a state's perspective and, you know, wondering what it would take in the way of incentivization to have most states continuing to accommodate the federal government this way.

So, it's just sort of a way, a reframing of the question, same research, but asking the question in a slightly different fashion on the financing side.

COMMISSIONER HENNING: When we talk about CHIP coverage for pregnant women, I have an issue with covering unborn children versus pregnant women, because to me, it's all kind of the same thing. I understand that there's slight distinctions between the two, but you're basically providing prenatal care so that those unborn children are healthy, which actually saves us money in the end.

Of the 15 states that cover unborn children, you've got two of the biggest states as far as births to undocumented women, and I know that's the 800-pound gorilla in the room when it comes to Medicaid coverage, but when you look at these women, they're the ones that don't have any other options for coverage. So, those women -- and, we don't have numbers in Slide 3, so it makes it a little bit more difficult when you look at Slide 3 and Slide 4. In Slide 3, you're looking at about 330,000 women, and that might be total, but it's one-third of a million women. And, when there's four million women giving birth each year but only two million of them being covered by Medicaid, the denominator really needs to be two million, and that's where I get my 17 percent of pregnant women who now look like they're going to lose coverage if CHIP goes away.

So, this is a real big issue, and it's an issue among people that are undocumented, have difficulty finding work because of their undocumented status even if they wanted to work. You know,

whether they should be here or not, that's a question I'm not even going to get into because that's -- you know, they're here, and we're going to pay for those births and we're going to pay for those unhealthy babies if we don't cover them somehow.

MR. PETERSON: On the eligibility questions, we have, just so you know, we've reached out to CMS to ask whether -- several things. One is whether states whose CHIP program ends, separate CHIP program ends, whether they could expand coverage with Medicaid, notwithstanding MAGI, and part of that question is also would it be possible for Medicaid to cover unborn children regulatorily, because, as you recall, it's permitted in CHIP through a regulatory change, so whether that might provide a vehicle in a post-CHIP landscape. And, so, it will be helpful to have an answer on that, and we've asked the same question with respect to pregnant women, as well, in terms of what the flexibility is as state option to expand Medicaid.

COMMISSIONER COHEN: Thanks so much, Chris, for a great presentation.

I just wanted to follow up a little bit on Sara's comments and maybe take them to the next level and pose a question for us. You know, when you work in the Medicaid program, and we, as MACPAC, are sort of frequently -- issues around matching rates try to come before us frequently, and the question is, whose responsibility should something be, more state, more federal? Should the balance be tweaked? And, personally, I've often felt that that's not a very good place for MACPAC to weigh in.

But, I do feel like, in this situation, it is a little bit different, and I just wanted to explain why and make sure my facts are correct, too. You know, in this case, there is really no -- we're not sort of being asked a de novo question, should the states or the federal government take on more of the responsibility for paying for CHIP. There's a lot of kind of evidence about what was intended here, in general.

For one, you know, over a long history, the federal government has said, we want to take on a greater responsibility for children than for other populations. We've prioritized this population and we

want to incentivize states in some ways to prioritize this population.

And, then, you have some mixed messages in the ACA, but the key messages that actually go to allocation of the responsibility really say, so, first of all, for newly eligible populations and higher-income populations, the federal government said the subsidy is 100 percent federal, generally. You know, in Medicaid, it's going to go down a little bit, to 90. But, sort of, again, taking on a greater federal responsibility. And then, specifically with respect to CHIP, they said, we're going to bump up the matching rate. The one place where they actually expressly sort of talk about the matching rate is, we're going to bump it up 23 percent.

And, then, there are some contradictions in the bill, and they said, but, we're not sure how this program intersects with the exchanges, which are 100 percent federally funded, and so, you know, we're sort of making a decision now, or some decision, and these goals were never really fully reconciled and debated to say, we're going to not authorize the funding past a certain point in time. But, that's not an allocation decision. That's just sort of a, we haven't figured out our next step decision, in my view.

So, I just wanted to sort of lay that out as a way of saying I do think that this issue of the state and federal responsibility comes to me, at least in this issue, a little bit differently than it does in others, and I wanted to put that out there and get some reaction and also make sure I have my facts correct that those are the sort of key messages that we've gotten about children and the federal government's role.

MR. PETERSON: Yeah, that is correct, and that's why this Slide 11 was in particular to try to show how that varies by state. I mean, to go back to Sara's point of what would the world have been without CHIP is a good question, and this slide complicates that premise because states made decisions in their CHIP program, and now with respect to the Medicaid expansion CHIP program, they're stuck, if you will, with the financing piece, and the burden as they move from the CHIP matching rate to the Medicaid rate varies a lot by state.

And, so, that really means the key questions that we're interested in hearing from you has to do with this pie chart, and that is for the bulk of these kids, the half of kids for whom this is applicable, and with these different impacts by state, what are the kinds of options we should be looking at and bringing back to you in October.

And, then, for these other groups -- kind of to your point, Sara -- okay, now, this goes back to the status quo pre-ACA, pre-CHIP, and does it matter?

CHAIR ROWLAND: I think this is pointing out that the analyses have to be divided into two pieces. You have to look at what the options are for states that have separate CHIP programs, and then what the options are for states that have gone to Medicaid, and then what some of the options are to have states migrate into the Medicaid if they choose. But, clearly, the statute gave states two choices of how to do this and then they also have blends. But, they really are now falling, as I see it, into two camps, and we really need to look at the future options to see what the balance is between those two camps.

Richard.

COMMISSIONER CHAMBERS: I think my question has probably been answered in the discussion prior, too, but, Chris, what the question was going to be is on the 14 separate, that the states with separate CHIP programs. Is there sort of -- are the states showing their hands as to what they would do, or are they saying, are there so many unanswered questions as to know what they could do that we don't have a sense of where they may go when federal dollars are exhausted?

MR. PETERSON: I think there is a lot of uncertainty, because we had recommended the Congress extend CHIP by another two years. There have been bills introduced to extend it by four years. So, there is some watchful waiting of, let's hope that this happens and not have to think about it. I don't know, Sharon, if you have something to add, if states are planning for the worst-case scenario in the nearer term and what the implication would be of the CHIP money running out under current law.

COMMISSIONER CARTE: No, I think states are just now really beginning to grapple with this, as I was saying earlier. It really is just now coming on the radar of states involving the public in this discussion. Even though in my own state we have always had public discussions before the CHIP Board to talk about these coming issues, we now find ourselves at this point where it has to be dealt with. I think in our state, there was always concern that there would come -- we would reach this point where the state would be asked to assume more responsibility for children's health coverage than had been the case, you know, for the past 15 years.

VICE CHAIR SUNDWALL: Well, thank you, Chris. You have an inimitable way of making things seem extraordinarily complex --

[Laughter.]

VICE CHAIR SUNDWALL: And that's -- we appreciate your getting into the weeds and doing that. I'm not -- I'm not criticizing, I'm just saying you've enlightened us as to the complexity.

Going back up to the big picture level, I just -- this just begs for simplification. You know, we as a Commission have always kept talking about administrative simplification and what can we do. I mean, my head spins when I hear of your saying states are using Medicaid money to pay the difference in the premium of the CHIP versus the private sector. I mean, it's just a mess.

And, I think whatever we do on our analysis, we have to keep first and foremost, how do we make this more uniform and simple and feasible to administer, and I think that we have -- I don't know, we all know the ACA never was conferenced and all the glitches that are in it, but this is a great example of how we really must, as a Commission, step up and say we have an extraordinarily complex system that needn't be that way. Our intent is to give children access to care. How can we make it more reasonable and feasible, affordable?

And, I am perplexed and confused and disappointed that this is -- we're in the quandary

we're in, but I appreciate you pointing out the complexities of it and I just don't want the Commission to keep analyzing only and be forthcoming about we need to make this a more reasonable system to get care to kids.

CHAIR ROWLAND: But, in terms of looking at the options and bringing options back for us to consider in October, I am hearing that the Commission would like to know more about what the options are for the states that have Medicaid expansion, what the implications are for the states that are separate CHIP programs. But, do you as a Commission want to see approaches that even out, you know, hold everyone harmless for their coverage? Do you want to also see options that try to simplify and smooth out the financing, that look at providing a stronger federal role? I would say that we really want to see two or three ranges of options so we know what the cost implications are and what the differences would be for the states if we go with one approach over another.

Patty.

COMMISSIONER GABOW: Just sort of to key off David, who is echoing my simplification constant, but I think we have to help the federal government treat its schizophrenia, because --

[Laughter.]

COMMISSIONER GABOW: -- at one point, I mean, we're at a point with the ACA where we were trying to make coverage almost universal and take more responsibility of payment for that to the federal government. I mean, the 100 percent match for the new population only going down to 90. It's not going back to the old FMAP. And, at the same time, we're talking about no match for these children who we made a conscious statement that we really felt covering children was our first priority, which is why we did CHIP before we did adult expansion.

So, I think that trying to say the consistent -- how do we deal with the -- how do we help

create a situation in which we remove mixed messages? The clear message that we got from the federal government with the enactment of CHIP is that it's important to cover children, and it's important to cover them with a substantial commitment finally from the federal government, which in the ACA went up even more, and that we want to cover more people, in general, through either Medicaid or subsidized premium on the exchange with a higher federal match. So, if those are the principles that the federal government has articulated, then what is the pathway, the simplest pathway to realize those two articulated goals?

I think that's the question, that rather than necessarily try to dissect this into all the subsets and populations that -- or how it's currently done, I think deal with what we know has been articulated as goals and then how would that best be accomplished. It seems to me, that is the easiest pathway.

CHAIR ROWLAND: But, it also seems to me that underneath this, we have to recognize a big difference between Medicaid and CHIP. We keep talking about matching rates, but CHIP is a capped program and there were allotments and a whole lot of other financing complications that come with CHIP that are different than Medicaid, which remains an open-ended matching program.

So, I think, as you look at these options, you need to look at the differences between continuing the capped allocation and what that implies versus the open-ended matching.

Okay. I think, now -- one comment from Trish, and then we're going to move on.

COMMISSIONER RILEY: I'd just like to make a generic comment to the staff that I think this is -- the reframing that was in the materials is really very helpful and I think it's extremely responsive to what we did at the retreat. And, I just would like to say, Chris gets at the complexity. He digs at the onion. He finds it for us. And, then he has a magical way of making it simple and understandable, so thank you.

CHAIR ROWLAND: Okay. Joanne. We're welcoming Joanne Jee, who has just joined the staff and will now share with us some of the transition experiences that we've learned in the three states

that have moved their CHIP children in different directions.

* MS. JEE: Thank you, Commissioners.

CHAIR ROWLAND: I think you need to pull it a little closer to you.

SESSION 1C:

RECENT STATE EXPERIENCES WITH MAJOR CHIP CHANGES

MS. JEE: Okay. So, I am going to talk with you today about recent state experiences with CHIP program transitions in three states, Arizona, California, and New Hampshire. We're talking about this today because as the Commission considers the future of CHIP in children's coverage, these states might offer some useful insights into how those transitions might be as seamless as possible.

I'm going to start with a very brief overview of some of the factors that can affect a state's program decision, highlight some of the changes in the three states, and then talk about some of the key issues that surfaced during the program transition, and then move into a discussion of some considerations for future separate CHIP program changes.

I won't go into this slide in too much detail because we talked about it a little bit this morning already, but there are some factors in CHIP program decisions just to keep in mind. The first is the maintenance of effort requirement for children, which is in effect until September 30, 2019. You talked a bit about that, as I said.

And then, the ACA also established a minimum Medicaid eligibility level for children set at 138 percent of the federal poverty level.

Another factor in the states that we looked at in their decisions to make changes to their CHIP programs, were the need to achieve some cost savings, both administrative cost savings by consolidating the administration of their separate CHIP program with their Medicaid programs, as well as in Arizona, freezing enrollment in their CHIP program to control their program expenditures.

So, there's a lot of information on this slide, which we won't go over in too much detail. It is a high-level summary of changes in the three states. I'm going to just call out a few things for you.

In Arizona, that state closed enrollment, new enrollment in its separate CHIP program in January 2010, opened a temporary KidsCare II program, which subsequently was closed in 2014, in January. And, what happened there was the children who were under 138 percent of poverty were moved into Medicaid and children above that level were referred to the federally facilitated exchange in that state.

California and New Hampshire basically ended their separate CHIP program and moved those children who were enrolled into Medicaid expansion CHIP.

The other thing I want to point out to you on this slide is the difference in the scope of program changes. In comparison to Arizona and New Hampshire, you will see that California's change is really big. They moved substantially more children into their Medicaid CHIP expansion.

One other note is that in Arizona and California, their change really came part and parcel with other delivery system changes that were occurring in the state through a Section 1115 waiver, which some of you might know is a pretty -- it can be a sort of complex process of negotiation between the state and CMS.

New Hampshire's change was slightly less complex, much smaller change, and occurred through a state plan amendment process.

So as the states made changes, they did work to address some key issues. As Mary Ellen said, we are going to be working over this cycle to talk about some of these issues in greater detail.

This morning, we are going to talk a little bit about provider access and adequacy, continuity of care, covered benefits, and transition planning and monitoring, and what we can learn from the states that we looked at.

So with respect to provider access and adequacy, New Hampshire and California did take

steps to assess and address access to providers and provider adequacy, and interestingly, both states really focused on recruiting dentists into their Medicaid networks.

The states looked at overlap between CHIP and Medicaid providers and took steps to recruit providers who participated in CHIP and not in Medicaid to encourage their participation in Medicaid. Their approaches were a little bit different, but they both did this analysis.

The states also used incentives and tried to remove barriers for provider participation in Medicaid. This was particularly important for the dentists. For example, in New Hampshire, they allowed dentists to see their CHIP enrollees once they were in Medicaid but not take on any new Medicaid patients, and they also allowed them to keep their names off of public lists of Medicaid providers.

In New Hampshire, when providers declined --

CHAIR ROWLAND: And the reason for that was?

Burt, a comment?

COMMISSIONER EDELSTEIN: [Off microphone.]

MS. JEE: In New Hampshire, when the providers opted not to participate in Medicaid, the state got lists of enrollees who saw those providers and identified providers, alternate providers for those enrollees, and then reached out to the enrollees to offer them these alternatives.

And finally, California posts on its website its provider adequacy assessments, which they conducted for each of four different phases in their transition. Their transition was quite large, so it occurred over almost a year in four different phases.

So with continuity of care, as you know, a change in the source of coverage can lead to disruptions in care. In addition to encouraging providers who are in CHIP to join the Medicaid network, California offered some other examples of ways in which it worked to address continuity of care.

Health plans must cover treatment by non-network treating physicians, including PCPs, for a

period of up to 12 months, and with respect to dental, the Medicaid dental plan honors prior authorizations from the CHIP dental plans.

The state also implemented a process which they call a "warm transfer process" to help enrollees who call the customer service line seeking assistance in finding dental providers, to help them find dental providers who are accepting new patients and then helping them connect to make an appointment.

For children moving between coverage programs, the differences in covered benefits can be meaningful. This is especially true, of course, for children with special health care needs. We think this is less likely to be an issue for children moving to Medicaid where they will receive a comprehensive benefit pack and EPSDT services, but I think it's important to note that a key benefit issue that was raised in California in their transition from a separate CHIP program to Medicaid was that Applied Behavioral Analysis services, or ABA services, which are often used in the treatment of children with autism spectrum disorder, was a service that was covered in CHIP but was not covered in Medicaid.

Since then, CMS has handed down some guidance that the autism spectrum disorder services, the services that treat that, are to be covered under EPSDT in Medicaid. So California has taken steps to implement that benefit.

For children moving from separate CHIP coverage and moving to the exchange, we are still not really sure yet how the difference in benefits will work, and that's something that we'll be looking at. But as we've discussed with you previously and as the research seems to be showing, the benefits in the exchanges are likely to have more limitations or be less generous than those benefits in CHIP.

States' transition planning and monitoring approaches have varied among the three states that we looked at. California's approach, as I said, was -- the transition occurred over a year, and their transition planning occurred about over a year, as well. The size of their transition was quite large.

They developed implementation plans for each of the four phases, had those available for

public comment, and they were posted on their state website, as well. And the transition plans addressed specifically the changes that would occur to certain certificates that are important to children: vision, dental, and behavioral health care.

With respect to monitoring, the fourth bullet summarizes some of the data that the state issued in their monitoring reports on their website. We are aware that there are some concerns by the advocates with the data and the timing of the reporting for monitoring, but we thought it was important to note here the range of issues, in particular, the specific focus on certain services, again, dental, behavioral health, and as well, the alcohol and substance abuse care services.

So Arizona, like California, made its transition using an 1115 waiver and so carried with it special terms and conditions that laid out specific monitoring requirements. Arizona's transition plan, which also was required in the special terms and conditions, identified the populations that would be affected by their waiver and briefly talked about what actions would need to be taken, both on the part of the state and the enrollees.

So, for example, for children with incomes above 138 percent of the federal poverty level, the transition plan says that those children and their families would need to connect with the federally facilitated marketplace to enroll, and that's basically all that it says.

It did also include -- it did note that they would provide a notice to the enrollee, letting them know of the change and the steps that they would need to take.

Other areas, such as continuity of care for children who would be transitioning into the federally facilitated marketplace were not addressed in the transition plan.

In Arizona's monthly reports, they did address some of the things that are in the second bullet there: enrollment, applications, denials. What they didn't address were access to care measures. They might be somewhere else, but they were not in the transition plan, and they didn't speak specifically to

dental care or to behavioral health care or mental health care services.

I think it's important to note here that people are very keenly watching what's happening in Arizona because it's the first state that basically moved their CHIP kids or referred them into the exchange. However, so far, there's very little data to know what is happening to those children who were referred to the exchange. We don't know if they enrolled or not.

New Hampshire's transition, as I said, was smaller, in some ways, than California and Arizona's. The number of lives was substantially smaller, and the move, interestingly, in New Hampshire was to move the enrollees from managed care to fee-for-service because, at the time, their Medicaid program was still in fee-for-service. Since then, that has changed, but I have heard that that is a potentially simpler move to go from managed care to fee-for-service than what California did, which was to take some of their CHIP kids -- well, to take their CHIP kids into counties in California where there was no managed care and then to move all the Medi-Cal patients into managed care.

New Hampshire did focus on ensuring provider capacity, as we talked about a couple slides ago, as well as notifying enrollees of the change and encouraging them to speak with their providers to understand whether they were in the Medicaid networks or not.

The state plan amendment did not require any specific monitoring of New Hampshire, although the state did conduct some of its own monitoring.

So what can we say about the CHIP program transitions based on the experience of these three states? Data collection and monitoring differed for children moving to Medicaid versus the exchange. The states know which kids went into their Medicaid programs, but they really seem not to know, particularly in the case of Arizona, what happened to the coverage disposition of the children who were referred to the exchange.

In New Hampshire, there was a small population of kids who fell off the program, who are a

part of a premium assistance program, but my understanding from the state is that they don't have data, nor did they have the ability really to track what happened to those kids.

States made ensuring provider capacity and continuity of care a priority. So, as the Commission continues its deliberations, you might want to think about what steps could or should states be taking to require -- ensure provider capacity and adequacy, either on their own or on the part of health plans, which is what California did.

And finally, how much planning should states engage in prior to making the changes? As we said, in the case of California, the transition and the planning were extensive, but the change was extensive, as well. And so that level of planning and monitoring might be appropriate for a state making that level of change, but is it appropriate for a smaller state? So this is something that might be considered, as well as how transparent should that process be, and should that be optional or mandatory.

So that ends my presentation, and if you have any questions, I'll be happy to answer them.

CHAIR ROWLAND: Thank you very much.

We did discuss at our last meeting wanting to know more about how these transitions worked and what was going on, but I think this is very informative, also, if we are going to look at a possible option for states in the future is to move more children into the Medicaid program and/or the exchanges, what have we learned from here, and can we offer some guidance about things that ought to be taken into account in a transition based on this experience.

Questions from the Commission members? Patty.

COMMISSIONER GABOW: Well, to that point, I think it would be good if we could, as we looked at this, which isn't a big "n," obviously, three states, and they differed in what they did, so it makes the relative "n" even smaller. But what are the best practices? What do we think represents best practice, and shouldn't CMS have consistency when it's doing -- when it's permitting states to do this,

whether through a waiver or different process in the future, incorporate those best practices both in the transition and in the monitoring?

And it does sort of surprise me that no one would know what happens to the -- whether people actually get into a subsidized premium. I mean, you know the name, address, Social Security number of the children who were in CHIP. I mean, that's data you have, so it's relatively easy to actually contact a subset of those. I know it's a mobile community and all that, but it isn't like mysterious, "Oh, we have no idea who these CHIP children were." I mean, we do know that and down to a level of pretty detailed granularity.

It is not acceptable to say we don't know how to look at this. We certainly should be able to, and if we don't, Google could do it.

EXECUTIVE DIRECTOR SCHWARTZ: I think, Patty, just to add there, it is not for lack of trying on our part to some of that.

COMMISSIONER GABOW: No, no.

EXECUTIVE DIRECTOR SCHWARTZ: I think there are folks who it's not necessarily in their interest or in their mission to know.

COMMISSIONER GABOW: No. I'm not saying --

EXECUTIVE DIRECTOR SCHWARTZ: We actually tried a couple of alternatives and got some cooperation and less in other places.

COMMISSIONER GABOW: No, I wasn't saying it was our issue. I'm saying CMS should not let the states off the hook, that, "Oh, we can't possibly follow them," because that doesn't make any sense, given the data that they have in their hands.

CHAIR ROWLAND: Well, clearly, they can follow them if they choose, but it requires, obviously, resources to do such a study, and the state may not have thought that was in their priority list of

how to use their resources.

Sara.

COMMISSIONER ROSENBAUM: One other issue, which I've actually done some work for the Commonwealth Fund on recent months -- actually, Richard was very helpful in helping me think through what some of these issues might be -- that I think becomes a factor in all of this is, in those states that are using managed care arrangements or insurance arrangements, network, whatever you want to call it, to the extent that there is a prevalence of companies that participate in all the markets and that use a common network in all the markets, I think the situation may be very different, because really then what you are talking about is a back-office transactional issue, with still headaches for the company and headaches for the state and changes for the parents. But the family is inside a plan and has a network that doesn't necessarily have to change at all and shouldn't change at all.

And sort of a separate discussion in all of this is, again, putting aside CHIP, the issue for adults of Medicaid to marketplace transitions and can people, which I'm sure will become relevant this afternoon, common plans, common networks. But it's an issue here, as well, and so we may want to think about -- if we're making a list of transition considerations, one of the big issues is the extent to which states have thought about devoting some effort to trying a across their various subsidized markets now.

I mean, the exchange subsidy may be totally federal. The market is a state market, and so the question is whether states ought to be thinking about this issue, because even if CHIP remains, we have this tremendous problem of bouncing, and so whether you're doing it for transitional reasons or just for program management reasons, I think getting a sense from some of the large companies that are selling in multiple markets about things that could be done from their side to ease the problem would be good.

COMMISSIONER CHAMBERS: I just wanted to compliment Joanne. The work was really good, and the report, the draft report language; you really captured a lot of stuff. Molina Healthcare

was one of the plans in California that went through the transition that you talked about where your numbers show almost 10 percent of the CHIP kids in the country were transitioned during 2013, didn't go without its bumps in the road, but I think it was, as you pointed out, as all the planning that was done, it is to do such a complex transition.

Some of the issues that we faced county by county was participation of different plans in CHIP versus Medicaid programs and just what happened and the access to some of those providers who were willing to participate in the CHIP program because they were part of large multi-line insurers, like Sara was just talking about, where they didn't continue in the Medicaid transition that was trying to get those providers to continue to contract with the remaining plans is always a tough issue. But it is some indication as to how we could prepare for the future, if there was that need for that kind of transition, so thanks.

COMMISSIONER GRAY: Very good presentation.

Given that a quarter or so of these kids presumably are children with special health care needs, do any of these states have any idea what their issues are with access to specialists, network adequacy? This looks like a very sort of primary care access-driven -- I'm just inferring that. I'm not sure that that's true, but on the surface at least, it looks like it's just primary care, to get access to some doctor or health care facility. But the needs for this population are significantly different than that.

Any sense at all whether any of them understand at all what happened in the more granular level?

MS. JEE: Well, California in their -- California issued monthly monitoring reports throughout and after the completion of the transition, and they do address certain services, such as mental health care and the substance abuse services.

I don't recall seeing specifically specialty care services, other than that, but it doesn't mean

that it didn't happen. We could look into it a little bit further and do additional research into that.

CHAIR ROWLAND: Thank you.

Now we're going to transition to consumer protections for transitions from CHIP to exchange plans, and Veronica is going to join us. So we've gone from overall issues to the state financing issues to the transition to Medicaid, and now we're going to look at the consumer protection issues between basically CHIP and going into the exchange coverage.

SESSION ID:

CONSUMER PROTECTIONS FOR TRANSITIONS FROM CHIP TO EXCHANGE PLANS

* MS. DAHER: Thank you. I'm going to be talking about the consumer protections for transitions between CHIP and exchange plans.

So as we've been discussing, we have potentially 8 million people who may be transitioning from CHIP to other sources of coverage if CHIP funding ends under current law. And many have assumed that QHPs would be available to those currently in CHIP, but that may not be the case for everyone.

So we know that some of the most important consumer protections are going to be things like comparability of benefits, cost sharing, and network adequacy, which we're going to be discussing in further detail in October and December. But there are also key concerns during a limited transitional period.

So these things, when we talk about the gaps, we're talking about five main issues: gaps during a course of treatment or a previously scheduled procedure, for continuity for prescription drugs or durable medical equipment, for those hospitalized or suffering a terminal illness, for those with chronic issues or serious conditions, and for all enrollees, outreach and information.

So our task today is to consider two questions: Are policy changes to bridge these gaps

necessary? And is this action better taken at the federal or the state level?

So currently in CHIP and QHPs, there are consumer protections available for kids, but none of these really address the issue that we're talking about, which is kids moving from one source of coverage to another and needing support for continuity, for access to their providers, and other benefits during this period. And, in addition, this transition that we're looking at is unique because it involves so many kids, many states, and they're really transitioning to a type of coverage that's going to be very different from what they've had in CHIP.

So you have more details in your packet, but the current protections can be useful to think about as a jumping-off point, and these are things like continuous eligibility, facilitated enrollment, payment grace periods for premiums, access to out-of-network providers, out-of-network emergency care, grievances and appeals, and information for consumers.

So you have a side-by-side comparison of these two bills in your packets, but there are two current congressional proposals that directly address this transitional period that we're talking about. The first is the CHIP Extension Act of 2014. This was introduced by Senator Rockefeller, and it defines transitional coverage periods for those with certain conditions, as well as others.

The CHIP Extension and Improvement Act of 2014 was introduced by Representative Pallone, and it simply directs the Secretary to issue continuity of care regulations, but it leaves the details of those regulations up to the Secretary.

In addition to these federal proposals, we also have examples of some states that have laws or practices that directly address this type of a transition. So as Joanne mentioned, California has laws that provide for continuity during a defined period. This is only for those who are experiencing an involuntary change in their health insurance provider. In addition, Maryland has a similar law that provides continuity during a defined period in addition to also providing protection from balance billing during this period.

Massachusetts, which has historically operated its own state exchange, has provided for continuity between MCOs and the state exchange via its contracts with the MCOs. And Delaware, beginning in 2015, is going to be requiring their QHPs to put in place transition plans for certain enrollees who are becoming eligible or losing eligibility for public health programs. And, again, these are not going to apply to those who are voluntarily disenrolling from a QHP.

So when we're talking about these consumer protections, we're talking about transitional coverage so you finish a course of treatment, for current prescription drugs, for those who are currently hospitalized, and to allow enrollees with chronic, complex, or serious conditions to continue to receive care from their out-of-network provider. And, in addition, we're talking about outreach and information strategies for all those who are transitioning.

The scope of remedies for these issues can go in three directions: they can be broad federal requirements, they can be specific protections at the federal level, or it could be simply leaving the decision to the states.

So what staff would like to hear from the Commissioners is what you'd like to hear more about and where you need more information so that we can move this discussion forward.

Thank you.

CHAIR ROWLAND: Thank you.

COMMISSIONER MOORE: Veronica, thank you. This is actually interesting. Your slide about current state practices says it's examples. Do we have any sense of whether most states have something in effect like these kinds of practices or only a few or many? I'm just trying to get an idea of where states are on this. They've got a lot of other things they've been probably worrying about, so maybe they aren't very far. I don't know.

MS. DAHER: Right. So these are simply examples, and we'd be happy to look into this

further to see how extensive this may be in other states.

COMMISSIONER RILEY: Do we know anything about the financing of a bridge, of a continuity of coverage? If they're moving from CHIP to Medicaid, who pays for what?

MS. DAHER: I don't have an answer for the CHIP to Medicaid financing. These were examples of kids who were moving from CHIP to a QHP or on to private coverage.

[Comment off microphone.]

MS. DAHER: So the laws that I've given as examples, they're requiring the QHP -- the receiving plan to -- right, to seek to contract with the previous providers if the enrollee requests it. But if the provider is not accepting the usual payment rates and the contract provisions that the receiving provider offers, then they aren't required to provide this continuity during this transitional period. So the QHP, for example, would be paying its normal rates that it would be paying, yeah.

COMMISSIONER GABOW: Is there any information in the commercial space about what consumer protections are? So say you work for a large employer, or any employer, and that employer switches health plans from Health Plan X to Health Plan Y. So what kinds of consumer protections exist in that space? Which seems like that would have some relevance related to QHPs because essentially they are commercial business, although being subsidized by the federal government for the premium. And, similarly, do commercial managed care plans, when a member ends up being transitioned involuntarily from X to Y because of a corporate change, what happens?

I think having some insight into that might have some relevance to this discussion. I don't have any idea, but it might be useful.

COMMISSIONER COHEN: I do think -- I think it would be helpful to have a little bit more information about kind of standard practices out there. Medicare has policies -- they certainly have it for prescription drugs, I think they have it sort of generally for the Medicare Advantage program. I think

in the spirit of also whenever we can align, when there's a federal protection for, you know, people in the Medicare program, it might make sense to think that a similar one might be appropriate for the Medicaid program. In any event, I think that would be a really good place to start looking.

I also think that CMS informally in state plans reviews and things like that, they have some, I believe, informal approaches that they suggest states take when they are transitioning populations even now like from fee-for-service into a plan or something like that. And I think getting a feel for those would really be helpful, because, I mean, it does -- it strikes me, to take a first shot at some of your questions, there probably is a federal standard approach here. This isn't -- you know, people are people and moving from one provider to another is probably a somewhat common experience regardless of your geography, much more specific about your circumstances and your condition and your provider. And I do think that there is probably a real place for some federal standards, an area that I think has been pretty ad hoc in the Medicaid program over the years. So I would encourage us to really look at some best practices outside -- inside and outside the program.

CHAIR ROWLAND: Although there are practices related to the dual-eligible enrollments into managed care and practices around transition from fee-for-service to managed care within Medicaid that we could also look at.

COMMISSIONER ROSENBAUM: I just want to pile on this point. I think this is one of these issues that we absolutely completely do not want to approach as the first time this has ever happened. I think this is such a -- I remember when GW transitioned all 9,000 employees out of -- basically we were all in Blue Cross, and we moved to a different carrier, so this happens all the time.

I would start this kind of a project probably with some sort of informal staff discussion, bringing together a roundtable of representatives from a cross-section of the insurance/managed care industry, the companies, whether they specialize in one sponsored product or they are multi-sponsor, and

go down the list of the issues. Whether you're talking Medicare Advantage plans, an ERISA-governed plan, a CHIP-financed plan, an exchange-financed plan, a Medicaid-financed plan -- there are companies that are in all of those lines of business at this point -- I'd try and bring them together, find out what their best sense of, you know, an industry standard might be, which is not going to be written in, you know, binding by-laws, but it will be a general practice.

And then I think what the Commission has to think about is where we can bank on an industry standard sort of as -- you know, this makes sense and, if this is what the industry does, that's fine. And where the issues are complex enough so that we want to recommend to Congress something, whether it's a condition of participation for states, whether it is, you know, a federal exchange protection, whatever, but so that we have some feel when we're making a recommendation to Congress that we're not just coming at this as if nobody ever had to think about this before, but our recommendations are sort of, you know, an evolution from industry practice, because I think otherwise we end up looking way too regulatory, and as if we've gone right to the issue of regulatory first without being able to say, you know, this is where -- the other thing is, of course, the Affordable Care Act addressed a number of these issues in the consumer protection section of the ACA, so we definitely want to know what the federal legal baseline is here.

COMMISSIONER CARTE: Yeah, I'd just like to follow up on Sara's comment that I think that states do this all the time. Our CHIP program just took the steps -- our children are still transitioning into the state Medicaid expansion. We took the steps of assuring that dental services that were prior authorized would be honored and informing the dental community, letting families know that if they had issues where they needed help with care coordination, we would work with them on those.

For me, the ultimate consumer protection question is, you know, what happens to families that are transitioning from a plan that has 95 percent actuarial value to one that has 75 percent or one that has now a $1,000 deducible for services where children won't access them, and those are the important

questions.

CHAIR ROWLAND: Thank you. Thank you, Veronica.

I think we've engaged in a broad discussion this morning of the issues facing CHIP. We've only touched the surface of these issues, but it's clear that, going forward, and for our October meeting, we would like to see more development of options and approaches that could address the many glitches in transition issues that we talked about this morning, really looking at the difference between states that have elected to go with a Medicaid expansion for their children population versus those with separate CHIP programs, the implications of that for transitions in the future. Are there better ways to accommodate the coverage of children in the future in terms of both what does it require to have them get comparable coverage in a QHP? What does it require if they're going into the Medicaid program? What are really the options on the table, I think as Patty so well stated this morning, for having as our goal how do we assure that these children get the coverage and the care that they need in whatever setting? And what are the options to address that as opposed to just trying to keep the framework that is so complex that we've already reviewed today, what's the framework going forward? So we will continue this discussion.

We've decided that having public comment only come at the end of a long day is not fair to either the public or to the Commission members, so if there are any individuals who want to make a public comment now, you can please come to the microphone. But I'm also told that NGAUS, our host here, is hosting a special art exhibit that's beginning at noon that is photos taken from Afghanistan by Staff Sergeant Sean Huolihan of the Wisconsin National Guard. And so if at our break anyone wants to take advantage of seeing this exhibit, it's outside in the hall. But thank you.

PUBLIC COMMENT

MR. HALL: Hi. I'm Bob Hall with the American Academy of Pediatrics. It's been a great morning, and I really appreciate all your attention to these issues.

One thing that I don't think I've heard through the testimony and the discussion was the issue of quality improvement and quality measurement, and I think some of the transition issues get to that. How do you make sure that you're buying something that is leading to improved child health outcomes? But that has been, at least for the academy, a focus of CHIP and SCHIP from the very beginning.

So we I think would certainly appreciate a continued focus on that. We want to make sure to Congress that they are investing in something worthwhile, and so, anyway, I just felt like that needed to be on the record in some way.

Thank you.

CHAIR ROWLAND: Thank you.

Any other comments?

[No response.]

CHAIR ROWLAND: Then we will adjourn and reconvene at 1:15. Thank you for your attention this morning.

[Whereupon, at 12:02 p.m., the meeting was recessed, to reconvene at 1:15 p.m., this same day.]

AFTERNOON SESSION [1:13 p.m.]

CHAIR ROWLAND: If we could please reconvene.

I am pleased to continue our meeting with our distinguished panel to really talk to us about Medicaid expansions via premium assistance, with a private option or the other issues that people have been looking at in terms of waivers that enable states to undertake the expansion with a different twist.

So Moira is going to kick off and frame our discussion and then introduce the panel.

SESSION 2:

MEDICAID EXPANSIONS VIA PREMIUM ASSISTANCE

* MS. FORBES: Thank you.

Good afternoon. This afternoon, we are going to revisit the concept of premium assistance or the Medicaid private option in which Medicaid beneficiaries are enrolled in private qualifies health plans through the exchange.

Last year, Chris Peterson presented on premium assistance as a mechanism for Medicaid expansion. At that time, a few states had floated the idea with HHS, and they have done some initial rulemaking. It was all around the negotiations about the Medicaid expansion after the Supreme Court made the adult expansion optional for states.

Since then, Arkansas and Iowa have implemented premium assistance waivers as part of the Medicaid expansion. New Hampshire is moving ahead with a waiver application that includes premium assistance, and several other states -- we heard from Vice Chair Sundwall today -- that have not yet expanded are considering similar waivers.

So we now have more information on the differences between the premium assistance model and the direct provision of Medicaid through fee-for-service or through contracts with Medicaid managed care plans, and we know more about the policy questions that this raises. We have also identified

more questions relating to the potential consequences of mandatory enrollment of Medicaid beneficiaries in private health plans.

So to assist Commissioners in consideration of these questions, we prepared a background paper, which is in your binder, and we have invited several experts to speak with you today.

Deb Bachrach is the former New York Medicaid Director. She's currently a partner at Manatt where she has worked with several states to develop premium assistance waivers.

Andy Allison is the former Medicaid Director from Arkansas, and he was instrumental in developing and managing Arkansas' premium assistance program, which they called the "Private Option."

And Lucy Hodder serves as the legal counsel to the New Hampshire Governor, and she is working with the New Hampshire Division of Family Assistance, Medicaid, and with the Department of Insurance there as they develop their premium assistance program.

So all three of our speakers bring a lot of both policy and operational expertise, and we hope that you will have a lot of questions for them.

For the benefit of folks in the audience who may not be familiar with premium assistance and the context of the Medicaid program, it refers to the use of Medicaid funds to purchase health coverage on the private market. While there are various flavors of Medicaid premium assistance, the models we are discussing today are programs that are operating under 1115 waiver authority to enroll adults in the expansion and in qualified health plans, QHPs, through the exchange.

Waiver authority was required to mandate enrollment into private coverage. States also use it to test alternate methods of demonstrating cost effectiveness and implement additional health care reforms as part of the demonstration.

The first two premium assistance waivers began enrolling -- that's Iowa and Arkansas -- they just began enrolling Medicaid beneficiaries and QHPs this past January, and CMS has not yet made any of

the required periodic reports available to the public. So MACPAC staff will continue to monitor the status of the demonstrations and will provide additional information to you as it becomes available. We are hopeful that information from the early adopters of the model will help clarify the risks and benefits, so that policy makers can better understand what it means for Medicaid to be delivered through a private insurance plan and under what conditions it might be -- what conditions might be appropriate to place on such a program.

The differences between the premium assistance model and direct provision of Medicaid and the potential consequences of mandatory enrollment in premium assistance raise a number of policy questions that we're asking Commissioners to consider, including how should the federal government ensure that states provide adequate oversight? To what extent should benefits and provider network rules for Medicaid and QHPs be aligned? Are protections for the medically frail sufficient if the new adult group in a premium assistance model receives QHP coverage, and are premium assistance programs cost effective compared to traditional Medicaid coverage?

I will turn it over to the speakers now, beginning with Ms. Bachrach. They can each describe some of the background and some state-specific issues and give you their thoughts on these policy questions. Each of them is prepared to speak for probably 5 or 10 minutes, which should leave us about 45 minutes for discussion.

Based on that conversation and your direction, staff can follow up at a subsequent meeting. We can bring you more analysis relating to these specific questions or other questions that might come up during the meeting.

So, with that, I will turn it over to Deb.

* MS. BACHRACH: Thank you. It is a pleasure to be here today. This is a model that I am particularly fond of. I think it makes a lot of sense. We started developing it with the state of

Missouri, but after the Supreme Court decision, the state of Missouri did not move forward or has not yet moved forward with expansion, and since then, I have been fortunate to work with both New Hampshire and with Arkansas in developing and, in the case of Arkansas, implementing it.

From this experience, I have some definite takeaways that I want to share with you. I will defer to Andy and Lucy on the details of their specific programs to the maximum extent possible.

So in its simplest terms, we are talking about Medicaid paying the premium for a qualified health plan for the new adults -- I say the new adults, the expansion adults, because that has been the focus to date -- in Arkansas, all of the new adults, and in Iowa, those above 100 percent of the federal poverty level. So Medicaid is paying the premium and then wrapping around missing benefits and cost sharing, so that the Medicaid beneficiary has the same benefits, the same protections, and the same limitations on cost sharing that they would if they were in a more standard or straightforward Medicaid model.

The target population, as I said, to date has been the new adults, and in all discussions, the medically frail have been excluded from the demonstration. Because these are mandatory programs, the target population is defined in the waiver, and to date, states have determined to exclude medically frail from the demonstration because of the sense that they would fare better in a more traditional model.

Now, importantly, the decision to seek a medically frail determination – "raise your hand if you're medically frail" -- rests with the beneficiary, and I don't think when we started this, we quite understood what an important statement that is, because when we begin to enroll Medicaid beneficiaries into QHPs, you can imagine that some of the QHPs, that some of the issuers would prefer that anyone they define a medically frail not be in their program, right? Let's keep the low risk, and the high risk should go.

So we started out thinking of this as a critical protection, and of course, it is for the medically frail. But we have learned that there are two sides to that coin, and I think it is important to say that the choice remains with the individual. If they don't seek or raise their hand, if you will, that they are medically

frail, then they continue in the premium assistance program.

If they seek a medically frail determination or they fill out the questionnaire, if you will, and are determined medically frail, they retain their right to choose between the Alternative Benefit Plan offered in standard Medicaid or the standard Medicaid. So they retain their right to the ABP, which has some additional protections, but it's outside of the demonstration. So I think in terms of the medically frail, it is working out quite well on the ground and I think on paper, as well.

I think one of the issues that hits you immediately as you start to implement, because I think the benefits of this program are enormous, the operational details are complicated. Each time we do them, it's a little bit easier, but they are complicated. And I think one of the issues is the relationship between Medicaid and the state insurance agency, the relationship between public and private coverage.

I only did Medicaid until the ACA passed, and I very quickly learned as much as I could about commercial insurance. We don't always talk the same language. The priorities are not always the same, but the way Medicaid approaches its role is very different than the way an insurance commissioner approaches theirs.

But for this program to work, it requires a partnership, which is why it's so important that the Governor's office in New Hampshire is involved, because both Medicaid and the insurance agency report to a governor. So that partnership is critically important, and when you think about Medicaid, when Medicaid purchases a QHP, that's not Medicaid managed care. So in Medicaid managed care, we have all the 438 rules, all of these requirements that the state and their contracted plans must meet.

Here, Medicaid is purchasing a private plan, a QHP that is regulated to some extent by CMS and to some extent -- and in some states, to a great extent, by the insurance agency. So that partnership becomes absolutely vital.

It can be institutionalized, if you will, and really, I'd say, need be -- but I'm not sure it's in law

-- but as a practical matter through two kinds of MOUs, one between the state -- between the Medicaid agency and the insurance agency and another between the Medicaid agency, the insurance agency, and the QHPs, because remember the Medicaid agency is turning over an awful lot of money to these issuers, and you certainly don't want to do that without some form of an agreement. And because they are regulated in the first instance by the insurance commissioner, that's why we felt the three-way agreement was so important. We can come back and talk more about what goes into each of those agreements, and Andy may want to say more about that.

So, bottom line, it's complicated to administer, but it has enormous benefits. So Medicaid has to pay premiums. Medicaid has to bring the cost sharing to Medicaid levels.

Now, there are two ways to do that. One is a two-card approach, individuals with a Medicaid card and a QHP card. An easier approach or -- neither is easy, but an easier approach is for Medicaid to buy the high-value silver plan or the 100 percent silver plan, so 94 percent AV or 100 percent AV, and pay up the cost sharing, just like the federal government does. So Medicaid stands in the shoes of the federal government and pays that cost-sharing reduction, if you will, so the Medicaid beneficiaries' costs are brought up to Medicaid levels.

We initially thought that was complicated. I think it's a better approach than the two-card approach. We can come back to that, as well.

But there are other ways. Benefits, not so difficult, because for the most part, the 10 essential health benefits are in the QHP. The 10 essential health benefits are in the Alternative Benefit Plan for the new adults.

We have found that the missing benefits, the misalignment, if you will, is pretty limited, and I would call out non-emergency medical transportation, which you know CMS has waived now in at least two states. And the other is EPSDT for 19- and 20-year-olds, and that in its simplest terms is dental,

vision, and of course, all medically necessary services. But that's triggered less. They certainly retain their rights, but that's triggered less in the dental and the vision.

There's some network issues, FQHC access, free access to family planning, all workable. So the alignment is pretty close.

Then you have other issues, and I think the one we've struggled with the most, quite frankly, is appeals. There are very clear rights in Medicaid. They stem from Supreme Court decisions, and had we aligned the two appeals process so they don't conflict, so someone can't go through a QHP appeal process and then start over -- and we have found ways to align them, but that was a more difficult process.

Another one that was difficult was plan selection. Unfortunately, the FFM, the federal exchange cannot accommodate Medicaid beneficiaries selecting a QHP. Hopefully, they will at some point, but right now they cannot.

So, all in all, it's complicated, but the benefits are enormous. There is a complete continuum of coverage, right? Same issuers. When you're below 138 percent of the federal poverty level, as above 138, same provider networks.

Access is improved. Now, I hesitate to use that. I often found advocates jump on me because it's -- is it better access? Is it better quality? We don't know, but what we do know is it's the same access as individuals in the private sector have, because you are buying a QHP. You are buying exactly what the privately ensured individual does, and you are increasing the size of the individual market, and you are increasing the number of plans available to Medicaid beneficiaries.

So we have increased -- and with an increased market, we bring in -- actually, we are bringing in younger people. So we are improving the risk profile of the individual market, and as Andy will tell you -- and I promise not to steal your thunder -- there are four-plus times as many private option enrollees in the Arkansas market as there are non-Medicaid enrollees, very important.

So let's come to the issue, the last issue, which I've labeled budget neutrality, cost effectiveness, and the GAO report.

Before I get there, I have two background points I want to make. Before premium assistance, take us back to 2010 when we're debating the expansion, and what's the biggest argument against the Medicaid expansion? Providers aren't paid enough. Your networks are too narrow. So we have done a complete 180 now, because now we have premium assistance where we are paying commercial or commercial-like rates, and we've moved Medicaid up from paying well below to paying Medicaid rates. And when we do that, we access the same network, the same providers that privately insured individuals do.

And think about the requirements of (a)(30)(A). Medicaid must pay enough, paraphrasing, so that Medicaid beneficiaries have the same access to coverage and care as others in the community. That's exactly what we're doing, and so I remain sort of baffled on some level with this, my God, we're paying more than we could have paid before. But those were the rates that everyone was so concerned about, and nobody -- you know, providers said they were too low.

Now let's talk about the GAO report for a moment. We know that this has been in dispute, an accounting dispute, if you will, between HHS and the GAO, and the fact is if you -- and Arkansas just became the latest target. So before we get into the numbers, I think it's really important to say could we look at what we've achieved in Arkansas, where 200,000 people are enrolled. Their uninsured rate dropped more than any other state in the nation, and because of the increased size of the individual market, we expect premiums to go down next year. So by any measure of success, they have been enormously successful.

So let's come back to the accounting dispute, and on a budget-neutrality point, it's that GAO takes issue with how CMS decided what Medicaid would have paid. When you are increasing Medicaid by 200,000 people, how do we know how much higher Medicaid would have had to raise its rate to have

enough access, to have enough capacity? And is it an unreasonable assumption that it would have to come to, more or less, the same level as the commercial rates? We are in a whole new world right now.

I just want to say one other benefit of doing this. So we now meet the (a)(30)(A) requirements in one fell swoop. You also get rid of the problem of supplemental payments. How many times have you and GAO and OMB sort of wrung their hands over supplemental payments, UPL payments, because you had to jerry-rig a system to bring Medicaid rates up to something providers could live with? And now we're paying providers commercial-level rates. There is no need for UPL payments. To me, that's one of the most difficult issues in Medicaid.

So then come back to cost effectiveness. Cost effectiveness wasn't waived. There is a huge evaluation plan, a rigorous evaluation plan to demonstrate cost effectiveness, and it is going forward, and it is going what we want to do. We are not just looking at a price-to-price comparison. We are looking at does the investment yield value.

And on that note, I will stop and I think turn it over to Andy.

* MR. ALLISON: Terrific. Thank you, Deborah. Are we on? Can you all hear me? Do I need to press it? Okay. Thanks for the opportunity to come talk to you today about the private option, which is everything Deb described and hopefully five minutes more.

Let me just make sure everyone understands what it is by describing it a little bit differently. As opposed to thinking of it from a population point of view, from a managed care versus QHP, I'm going to walk you through sort of the enrollment process and just fix ideas on medical frailty and the separation of these markets.

If I could, though, start with the purposes of the private option as laid out in the legislation itself, there will be debate and ultimately evaluation to determine whether this is fluff or stuff. But I can tell you it's the purpose behind it, and it will describe to you -- it will motivate this description. The

purpose of this legislation is to improve access to quality health care, which we've now done for over 200,000 low-income Arkansans.

Second, attract insurance carriers and enhance competition in the Arkansas insurance marketplace which is not Medicaid. We have now done that with, next year, three statewide competing carriers, which Arkansas has not had in the past.

Promote individually owned health insurance. That will be a point of argument and discussion for a long time to come, I am sure. But the introduction next year with pending now waiver requests for independence accounts, some increase in out-of-pocket costs, but also substitution of out-of-pocket costs for voluntary premiums to be built up towards an account that can be used to help with the individual's premium obligation above 138 percent when, as the majority do, they are on their way out of Medicaid.

Strengthen personal responsibility, improve continuity of coverage. Self-evident that that's now possible in Arkansas in a way that is maybe not possible anywhere else.

Reduce the size of the state-administered Medicaid program, not the size of the spend with Medicaid-funded dollars clearly, but in the eyes of the legislators who championed this, to focus Medicaid on the populations from a health care point of view that are different, not from an income point of view that are different, which is where medical frailty comes in.

Let me describe to you: an applicant now comes either to the healthcare.gov or to our own Arkansas-based eligibility system and demonstrates eligibility, and those who then are told you are under 138 percent of poverty are directed -- ultimately that will be a continuous single web session, not a direction. They are directed to the new website that Deb really only alluded to, which presents them with, in sequence, two things: first, a questionnaire asking them if they have limitations on their activities of daily living, if they don't live independently, if they've had meaningful use of psychiatric overnight care in the hospital, if

they've had a fair amount of recent health care use, an algorithm -- some of those are automatic qualifiers. Others contribute to an algorithm which we worked with AHRQ using MEPS data to develop, predicting ideally the highest needs 10 percent of the population. I actually think less than 10 percent of the people are medically frail. Insurance actuaries have no background in any of this and needed some care, comfort, and assurance. And we, of course, wanted to attract competition so we pegged it at 10 percent with that algorithm.

If you're below a certain threshold or don't meet those automatic qualifiers, you're in. If not, you're medically frail and you get a Medicaid card like other recipients, and nothing is different.

If you are part of the 90 percent that don't blow high on that questionnaire and that screener, you're immediately presented with the same choice of health plans that those in the marketplace receive. Again, this is an operational difference, not a market difference. It's just because the FFM can't figure out how to program the computers to do this that we don't actually send them there. We give them the same choices with as much information as we can give them about those silver tier health plans. Every health plan, by our own statute, that is in the marketplace must offer this silver tier plan and participate in the marketplace. And over time that means even without enrollment caps. You're in one; you're in the other, the same.

Initially all the cards were exactly alike, indistinguishable at the provider level from one market to the other, just to give you a sense.

If an individual over time develops the need for a service that is not offered as part of the essential benefit package, the ten essentials, they need therapy that goes beyond the limits in the reference package. They need long-term care. We are -- the state is; it's not me anymore -- developing procedures to do a couple of things for the health plans to look for those individuals by, for example, denied claims for something or their own care management processes, identifying these individuals, which, by the way, we

heard a lot about in the first month or two, and it turns out maybe they're having trouble meeting their MLR. I don't know. Very few individuals -- I'm not sure if we've transferred anybody yet.

You know, so in the first month, we were hearing from the health plans saying, "Wow, some of these people" -- key word "some" -- "really have a lot of need and are very high cost." And, "Wow, you know, we've had to hire someone that used to run or help run a Medicaid managed care firm to develop processes for this." In the end, those transfers, that alarm bell ringing of medical frailty, not so much. Not so much.

We've heard from the other side, those who blew high on the screen and who decided, you know, maybe they didn't know they would be labeled medically frail. So the pressure is the other way. It's into the QHP, not out of it.

The concept that Deborah described to you is, yes, the individual still receives the services that the statute, the federal statute, our state plans say that they can get -- long-term care. But they are not entitled to receive those services through the private health plans, and they're not entitled to receive those services at the same time they are enrolled in a private health plan.

Our answer to wrap-around services is actually not a wrap. It's to get those wrap-around services back in Medicaid. And that's what keeps us from having -- so let me describe, if I can find this, the definition of "medical frailty." I sometimes can find this and sometimes cannot. I'll read it to you later.

Our own definition is not actually "medical frailty." It is an individual with an exceptional service need. It's a benefit description, and amounts to those with -- who need a service that's not offered. That's what medical frailty is. If you need more, either in amount, duration, scope, or the benefit itself, we move you, because coordinating benefits is hard and undermines market leverage and oversight between payer and the source of funding, that is, the state and the payer.

So hopefully that gives you a practical sense of how this works. The point has already been proven in a sense. Yes, if you quadruple the size of the marketplace, and if you say that marketplace will absorb only the healthiest 90 percent of this guaranteed premium paid every month on time population of relatively young people -- because low-income and age turn out to be correlated pretty highly. We've lowered the average age, the median age of our marketplace as a whole by nearly a decade.

If you do all of those things, even private sector insurance actuaries will eventually figure out that this is a good place to start a business to come in and to build competition between carriers, which was the point -- which GAO, by the way, couldn't take into account in its assessment because the budget window for the neutrality in an 1115 waiver is Medicaid specific.

So let me say a little bit about cost effectiveness. Our demonstration of cost effectiveness was much tougher to our local legislators, because what they demanded was a federal taxpayer point of view, not a state point -- plainly obvious this is a good deal for the state. Everyone knows that. Not really even a meaningful debate. The question is: Does it cost the federal taxpayer money?

Well, I've described to you a blended market of insurance, which we assumed naturally would lead to a blended market of provider payment. And, therefore, not necessarily the pre-existing commercial rate of provider payment, but something in between. This is now written into Pennsylvania's waiver, without numbers, because they've adopted the concept that the amount will end up in between, somewhere between what Medicaid provider rates were and what commercial rates were, that that's conceptually what it takes to earn your way into that provider's office or inside their walls. And we decided that we as a state wouldn't be any better or maybe even as good at figuring out what that amount is than private and competitive carriers. If there's competition between carriers, then how can we do better than to rely on that resulting price, competitively determined, for entry into the provider's market?

Let me actually read to you -- you've done it. I know that MACPAC has done this,

reviewed that chapter two years ago in your first or second report. 1902(a)(30)(A) says, "A state plan for medical assistance must provide such methods and procedures relating to payment for care and services as may be necessary to ensure sufficient" -- "that are sufficient to enlist enough providers so the care and services are available under the plan, at least to the extent that care and services are available to the general population in the geographic area."

The toughest part of that in the past has been defining what the general population in the geographic was, and it's been -- you wrote about this. It's very difficult to figure out how much it takes and how to demonstrate that that access is actually equivalent. We're sort of bypassing the math, and just assuming that what it takes is what it takes, and that, in fact, the point of reference in the federal statute for access is about as close to the definition of the marketplace as you can get, that is, what the general population has in your geographic region.

I think it's tougher for GAO and for others to argue that we could do it for less than it is to argue that we're paying too much, if the test works, if the experiment works, and if the demonstration actually does generate competition among carriers, which we certainly have the market share to do.

I'd love to talk to you about benefits and other issues, but actually Deb did a very good job of presenting that. I probably ought to stop and take questions after Lucy.

* MS. HODDER: Okay. Thank you. I could stop here because I agree with both Deborah and Andy immeasurably. I want to thank you all for allowing me to be here from New Hampshire. I think a little preface of what I'm going to say is demonstrated by the fact that I am actually here from New Hampshire talking about our Medicaid expansion and our implementation as the sole lawyer in our governor's office other than the governor herself, meaning that we are incredibly excited about what we're doing but doing it with the excitement and resources that come on a very, very, very small staff and very busy group of executive branch folks.

I want to talk about three things that are not specifically the answers or the response to each of these questions, but sort of flow beneath them. I'm coming from a small state where about 130,000 of our 1.4 million citizens are on Medicaid. That includes 11,000 who have come on to the rolls this year in regular Medicaid because of the MAGI change. And we're anticipating an additional 50,000 to come on as newly eligible in our Medicaid expansion, of whom 16,000 have already signed up. So it's a great change, but those are the numbers we're talking about.

And what's critical to remember is that the timing is everything, and that's both the timing of what's happening on the marketplaces and the timing of what's happening in Medicaid. And that was true for our state and why we have a premium assistance model that we're trying to implement.

The other thing which I hope I'm allowed to talk about in Washington, D.C., is that the politics of both of these issues matter. They matter significantly. We are balancing on a high wire at any given moment on this issue, and it really matters to how things proceed, how things are defined, et cetera.

And it also matters that premium assistance is and continues to be a good idea -- a good idea for our markets, our insurance markets in New Hampshire, a good idea for access to care, and I might go so far as to say that includes not just covering individuals with insurance they've never had before and reducing uncompensated care, making sure they're getting care in the right, most efficient place, but things like the substance use disorder benefit is huge in New Hampshire. And if we do it right, we may see an incredible change in costs that are elsewhere in the system. So access matters.

Also, it matters as to how this impacts the New Hampshire budget, which brings us right back to politics. It really matters what comes down in terms of oversight, regulation, changes, and how that impacts our New Hampshire budget as to whether we can continue on.

So I just wanted to talk a little bit about those things and how we got there.

With regard to the timing, I'm going to illustrate what happened in New Hampshire to show

you that the marketplace development is integrally related to how we came up with a solution to Medicaid expansion. When the governor came into office in January of 2013, the first thing she had to do was to declare a partnership around the marketplace exchange. We're a plan management state. There was a law on the books that was reiterated that we cannot have a state-based exchange. So anything we do relative to the marketplace, any regulation relative to PPACA, has to go through a legislative committee.

So our exchange is very much tied to how we've developed regulation around it, or lack of regulation around it, in the state. It's an FFM, it's a plan management partnership, and that's as far as we can go.

Then we also were implementing a formerly passed obligation to transition our entire current Medicaid program to Medicaid managed care. When we came into office, the governor, the Medicaid managed care was not yet up and running despite efforts to secure contracts with providers for two years. However, as of December 1, 2013, we implemented Medicaid managed care for the acute-care population, so for the health care population primarily. And we're working towards moving in long-term care and developmental disabilities, the waivered populations. And Medicaid expansion brought in the newly eligible population to managed care.

We tried to get Medicaid expansion with the budget the first six months the governor was in office and we failed. We then had a commission who studied it all summer. During the time the commission was meeting in the summer and fall of 2013, Arkansas got its waiver, and Iowa then got its waiver. There was also a government shutdown, which resulted directly in certain limitations in our own bill around the FMAP. So all of that timing mattered.

There were intensive negotiations around expansion. We called a special session, the governor did, in November of 2013. It again failed. And it failed because there was a battle between managed care and the MCOs who were providing our managed care at that time, and their expectations, and

the political desire to have a private option, and when we would be ready for it.

At that same time, the marketplace came into being. Open enrollment happened. We all learned in November of last year we had one carrier providing plans on our marketplace in New Hampshire, Anthem, and the plans it offered were narrow networks. And the plans they offered were providing provider rates -- they had negotiated provider rates that were closer to Medicare and very, very different from the commercial market, group market off the exchange.

So all that was happening as we were negotiating Medicaid expansion. It resulted in a successful passage of our New Hampshire Health Protection Program, which was signed into law on March 27th by the governor, and we implemented the managed care portion of it, which is the bridge plan, for 18 months. We implemented it with the help of Deborah and significant team work with our Department of Insurance and Health and Human Services and our Medicaid program, so that enrollment began July 1, coverage began August 1, managed care began September 1.

So we are up and running with expansion, and now we have to develop our premium assistance waiver, which, if we do not achieve approval for our premium assistance waiver by March 31st, the plan expansion ends.

So that's a little bit about our timing in New Hampshire that brought us to where we are today, which we're in the final stages of -- we're going to be putting our notice, our public notice of our waiver, our premium assistance waiver up beginning October 1, so in just a few weeks. And we have to have it submitted to CMS, according to our statute, by December 1st. And then we need to have approval by March 31st, and there are several legislative committees between here and there, just to reassure you.

The politics of it, as I said, we have a Democratic governor, a Republican Senate, and a Democratic House. We don't know what will happen in November. What mattered to everybody in New Hampshire is that -- we have a real history of guarded compassion and accountable compassion.

What mattered a lot was having some very -- it mattered a lot that Arkansas was approved within the guidelines it was approved, because there were clear corridors for a public-private option that were established, but also some flexibility within that so we could assure those who were concerned that we would be able to develop somewhat of a New Hampshire model. So it really mattered that there were corridors, but there was some flexibility within them. That made a big difference.

The key things that mattered were reducing uncompensated care, the substance use disorder benefit, the offer of 100 percent FMAP -- our program is only three years long, or until the end of '16 -- and expanding coverage while encouraging personal responsibility is really what motivated the private option.

There was a huge incentive to make sure our insurance markets were stabilized and benefited from bringing the newly eligible population into the marketplace. That was a huge deal. We only had one plan. We have five coming on for 2015. So that mattered a lot.

So the good ideas, the good ideas that must be sustained as these questions are answered are, first, that this population of zero to 138 percent has continuity of coverage. There's a lot of fluctuation in income in New Hampshire, as everywhere else, and it mattered a lot that we could achieve continuity of coverage through the premium assistance model.

The other thing that mattered a lot was making sure that we attracted more plans to the marketplace. The narrow networks were a concern, I will say, when we were developing this legislation, because of the difference between the network that was available in the exchange products and what the Medicaid network definition was. So, it does matter, but at the same time, because of our network rules are fairly flexible, we were able to achieve a pretty good resolution for the future models and moving Medicaid to the premium assistance, we hope.

What we also were able to do was to help use this potential population as a way to bring some stability between the private and public markets for the providers. So, it is, as it happened in

Arkansas, a little bit of a transition step, the marketplace plans, and so we've brought the providers into a little bit more of a stable, accessible model through our managed care bridge plan, and that's made a big difference in terms of access for what is a large number of new enrollees in the Medicaid plan. And, we certainly hope that that transition to the premium assistance model will continue to maintain stability and access in the provider market. That's critical.

But, again, we call it commercial. It is the marketplace plans, but they're slightly different from the commercial plans that you might see off exchange because of the way they've been set up. So, that will impact, I think, our cost effectiveness and budget neutrality comparison.

The other thing that's critically important in New Hampshire is to make sure that we can keep what we've learned in our Medicaid managed care model and translate it into the private insurance market without either scaring away the private carriers in the process, and what we really focused on is the patient-centered model of care. And, we are looking forward to how that is managed in both the managed care model and then as we move to premium assistance, how we can translate what works well into the premium assistance marketplace.

That's a challenge that we're struggling with right now and trying to figure out how we succeed at, because we -- in the insurance world versus the Medicaid world, that's one of the areas that insurance regulators are typically not really looking at, whether the models offered provide patient-centered care. That's not really their motivation, while on the Medicaid side, it really is. So, merging those two worlds is something we're looking very carefully at, but trying to respect what is the essence of insurance regulation at the same time, which is to encourage healthy, steady, and robust markets in the insurance side.

I would say the critical, just to restate, the critical thing for us is clear guidance with flexibility. It's also mattered a lot to us that we have been able to create a team where we're trying to have insurance talk with the same language as Medicaid, which is a huge learning curve for both sides.

And, I would say we've been successful, for the most part, because of how much everybody wants this to succeed and how much it matters to make sure there is coverage and stable markets and access for all of our population as they grow out of the very poor into the working poor and on through their successful lives. So, that's a very important underpinning for all of us.

It is critical that the agencies understand each other. It is critical that any change to the marketplace will impact Medicaid because of this and vice-versa. And, we've been blessed with very good teams at CMS who know New Hampshire well, have worked with New Hampshire for a long time, understand New Hampshire, both our good and our bad aspects, and have, therefore, made reaching a resolution -- with some tough love along the way -- something that's been a very good team approach. And, I will reassure you, it's been some tough love along the way, and we expect to continue to see that.

What is important is that we get the same from the CCIIO side, that there is communication on both sides so that our marketplace discussions and our Medicaid discussions can somehow be consistent as we move to premium assistance. That's a tough one.

So, you know, I'm sure you hear this from every state and you know it from what you do in your other lives, as well, but every state is slightly different and it's based on the timing and the politics and the make-up of the state and the insurance status of the state, but it really does matter, those differences, as they impact this merger of private and public on the premium assistance model.

We are -- it will be very interesting to see how New Hampshire survives as an FFM state moving forward with our premium assistance, but we're very hopeful that we can work things out in a way that creates a premium assistance model that is really good for those we are providing access to, especially in partnership with the CMS and in the way we've been able to thus far.

So, we're very excited. We're nervous and hopeful. And, I'm happy to answer any questions.

CHAIR ROWLAND: Being hopeful is always good.

I have Trish, Denise, Sara, Patty, David, Judy.

COMMISSIONER RILEY: Well, this is intriguing stuff to me, because I think, Andy, you've all pointed out the sort of conflict between Medicaid and insurance, and I think what we're dealing with -- the GAO headline was, of course, pretty striking to all of us, is this smoke and mirrors, but, I think, Andy, you've raised the essential point here. What we're dealing with, it seems to me, is an historic Medicaid program rooted in an old way in the old days, when there was Medicaid here and insurance here. The ACA blends those. Those lines are no longer bright lines. We now blend it with a subsidy program that moves from Medicaid to private insurance. So, we need to think differently about health coverage and we need to think about health coverage as all of those things as a state.

So, I'm very intrigued by your point, Andy. If we're going to move there, which the ACA seems to do so, then premium assistance as you designed it makes lots of sense. But, the measure against which its success should be tested is the whole system.

So, the question I have -- and, I think that's right in an ACA world -- would be, could each of you -- and I know New Hampshire -- I'm from Maine -- I know New Hampshire a little bit better, and I know Anthem quite well, but you noted, Andy, that you've seen more competition. Can you talk a little bit -- it's early, I know, but what has been the implication for the exchange in terms of competition and premium prices as a result of these folks being in a private plan?

MR. ALLISON: It's a great question. I probably didn't sleep much between the passage of the bill -- oh, sorry. I probably didn't sleep much between the day that the Governor signed the bill and five weeks later when we had to get instructions -- when the Insurance Commissioner had to re-release its direction -- whatever they call it -- issuer bulletin for QHP certification, which was, in a technical sense, the announcement of the making of this new market for the re-making of Arkansas' insurance market, after

which those companies had, I don't know, about two weeks to decide whether they were going to play.

That's what drove the timing, actually, of the legislature's decision, was backwards mapping that decision process. Translation: The rates and the participation in our marketplace in 2014 really are not a reflection of the underlying health of this marketplace because they didn't have time.

So, we had one -- really, we had one dually issued Blue Cross, local Blue Cross, national, that was statewide. The other two that played in various regions around the state since have both decided to go statewide. One of them got themselves bought out in order to do that and to provide the capital to make it happen. So, we have, more or less, tripled the number of companies in one year that are offering statewide, but Delta will see real insurance competition for the first time in its history.

COMMISSIONER RILEY: [Off microphone.] What are the rates going to be?

MR. ALLISON: So, the rates in 2015 are not known yet. There have been some early inadvertent, depending on who you talk to -- at least, to my knowledge, they are -- release. Here's the problem. You had private insurance actuaries guessing as to the cost of this thing. You had a marketplace that didn't know how savvy the state would be in coordinating between the Insurance Commissioner and the Medicaid program to insure through market making activities like auto-assignment. When was the state going to introduce a price target or a ceiling? When was it going to switch to subsidizing fully only the second-lowest cost, or silver tier plus or minus five percent?

Those things -- we had five weeks to make a market, send a signal for the next three-year trajectory. We didn't quite get it done in five weeks. Those are the things that have to happen now, because, clearly, the state eventually has to be price sensitive in what it purchases from the marketplace, and there's been a pretty strong signal that that will happen, really, in 2016, which is the third and final year of the approved waiver.

In the meantime, the early signals are that premiums, on average, weighted average, won't go

anywhere in 2015. That's kind of the best, plus or minus two -- well, you know, it hasn't been determined yet. And, part of the issue is, how savvy -- not any new plans, but the plans that were only partly statewide, raising the question, would it be more competitive if we had ten plans than if we had three statewide? I actually don't think it would be. The state hasn't made that strategic choice and hasn't declared what it thinks competition is.

I would ask you, what state has? Has the federal government said, this is what we think? Have you all done that? And, ultimately, who will, because, you know, is this a Medicaid, or is this -- is this CMCS or is this CCIIO? Is this MACPAC or is this whoever it is that advises Congress on exchanges and marketplaces, right? And, if this bucket over here is empty, I would encourage you to fill it, but, obviously, that's a tenuous -- you have to work, and I would say the same thing to Congress, as well. Someone needs to fill that.

Just like it's difficult to work with Insurance Commissioners at the state level to decide what competition means -- which Insurance Commissioners have never done in their lives, okay -- that cooperation and that policy vision needs to come here at some point, as well, to succeed in getting those premiums down and that competition up.

MS. BACHRACH: But, just to emphasize, and very quickly, something Andy said, this was effectuated through a lot of head-knocking, a lot of discussions between Medicaid and Insurance where decisions found their way into issuer bulletins. So, if you -- you made a release, as you were alluding to, we were merging the two markets and trying to take the best of both in that five-month period with more coming. But, it was through the vehicle the issuer bulletin that Medicaid was able to influence the market in very meaningful ways.

MS. HODDER: But, it's going to play out a little differently in each state, and that's going to be -- sorry. It's on now. It's going to play out differently in each state, and we're -- our timing is

slightly different from Arkansas. So, our Insurance Department is thrilled with the fact that we have five carriers now offering plans on the exchange and they're terrified that the premium assistance could somehow undermine the successful competition.

Now, we think, actually, that the additional lives can, in fact, enhance the competition and will do so, and we are very encouraged that that will be the case. So, it remains to be seen. I think we're going to have a good 2015 year and I think that the premium assistance will just improve the market.

COMMISSIONER HENNING: I was wondering if you could speak, both from Arkansas' perspective and New Hampshire's perspective, about the change in doing it this way, the premium assistance. Does that change the beneficiaries' access to specialty care?

MR. ALLISON: I would argue that it depends on which specialty care we're referring to. Of course, the marketplace is exhibiting, you know, demonstrating across the country a new set of benefits, in particular, behavioral health with parity, real parity, and the therapies due to rehabilitation and habilitation, which conceptually had no definition, either in the federal law, and varied interpretation around the country in the Medicaid program. I think that's an open question, what access to specialty care and specialty services there will be within the private option.

What we did is make sure that there was an alarm bell everybody could ring. If you need what you think is over here in Medicaid, which, you know, we'll see if the networks are as robust -- I think they will be, really, due to the social compact we have with the medical community to keep serving Medicaid recipients, even though at a lower rate -- but, you'll have an individual choice, which is better for the individual. Is it, again, is it the benefit definition that matters to the individual? Is it the provider network? Is it something else about private coverage that is really going to serve them?

MS. HODDER: Our hope is the access will be improved. I mean, this population is newly covered in terms of we did cover parents with very low incomes, I think it's up to 45 percent, 47

percent. So, the hope is, yes. I think what we're struggling with right now is to what extent personal responsibility will keep this population from participating, so we're making those judgment calls as we speak. It's critical that they participate, or access to the specialists, and the pharmaceuticals that go along with the need for specialty care, is available. But, we certainly hope that both the improvements in our Medicaid program and as we transition to premium assistance will improve access to specialists substantially.

COMMISSIONER GABOW: Thank you very much. This was quite interesting. I have three questions.

The first is, government programs don't have a profit line in them, but, of course, private insurers want a profit in there. So, how does profitability fit in budget neutrality, which wasn't in government programs? So, that's my first question.

The second is, how are you handling FQHC cost-based reimbursement?

And, the third is perhaps more philosophical than practical, is you all sound like you think premium assistance is really a great idea for all the reasons you presented. So, do you think that all Medicaid should go to a private marketplace model with a wrap-around of some sort for those services which would not ever be offered in a commercial business and enable you to get rid of things -- simplify things, get rid of UPL, et cetera, et cetera?

MS. BACHRACH: [Off microphone.] Shall I start, and then we'll go down the line? On the no profit [inaudible] government program -- did I not hit it? Now can -- that's it, yes.

You make a really good point, because in starting our budget neutrality, in Arkansas, we started with a fee-for-service model. So, Medicaid has already accepted the notion that there is a profit or a savings line, a margin, because we have Medicaid managed care where we have some limited margin or profit. So -- but, we weren't starting with that. In Arkansas, you were starting with a fee-for-service system. When New Hampshire comes in, you're starting with Medicaid managed care. So, I think that

the point you're making will, of necessity, be built into the system and was maybe a point we ought to come back to GAO on, on Arkansas.

So, let me go quickly so my colleagues can answer. I think FQHC rates, the FQHC requirements apply. FQHCs remain entitled to the PPS rate, whether it's required to be paid by the -- well, you're not -- it's paid outside by the state and there has to be at least one FQHC in each service area, so I think that becomes a non-issue.

And, is it such a good idea we ought to extend it to all populations? I think we ought to be thinking about it. I think we're doing it just how we started Medicaid managed care, right. We started it with moms and kids. As we got better at it, we brought in other populations. I think it's premature to say everybody but the medically frail, everybody but the aged, blind, and disabled. Maybe that is the right place. I think it's premature. I think we need to see what happens with CHIP and so on. But, I think it's the right question to ask three years down the road.

MR. ALLISON: I would only add to Deborah's characterization of profitability with the following. You know, I purchased care -- state employee health plan, Medicaid -- in two states for eight-and-a-half years. I can tell you, I don't know exactly how to make health care efficient in every case, and I think that the profit motive can serve a very useful purpose in attaching outcome to payment and to ensure that there's a reward for the investment that health care providers or the glue between them can invest. No reward, no investment, no efficiency is the problem with eliminating profitability.

The reverse of that is if the public is purchasing care without regard to the level of profit. That's where I think strategic, wise, and, ultimately hard-nosed purchasing or rules for competition come in.

You've identified, really, this, as this is the guts of the experiment in Arkansas will ultimately be not about, sort of, whether commercial pays here [high] and public pays here [low]. It's about whether competition results and whether that competition can be used to come to a reasonable level of profit so that

we're compensating the carrier for what it's really doing or adding to all of this equation, which ultimately is a policy question.

FQHCs are complicated here. You know, we've got a set of HRSA guarantees and we've got a CMS set of rules, and states are kind of caught in between. They just are. We wrote into our waiver the opportunity for FQHCs to decide that they want full participation in the QHPs, et cetera, by agreeing to something other than PPS. They haven't done that yet and there's a process of trying to figure out how much they're actually making and what the cash flow really is now that we have, again, the largest reduction in the uninsured in the -- that's got to have some impact on the bottom line of safety net providers of all kinds, not just the FQHCs. I think that's -- long run, I think that should be an empirical question and we shouldn't pay FQHCs twice for the same thing, once through reimbursement and the other through some excess cost base for the uninsured that aren't there anymore.

Should all states do this? No, I don't think so. We're starting from different places. You know, those who have managed care already, not necessarily. Iowa chose to do this really for just a piece of its 100 percent to 138 percent.

The other part of your question was the wrap-around. I have intimated this already. I don't know of a purchaser that has had any luck coordinating between -- with another purchaser of care and trying to figure out where one benefit ends and another begins. So my own personal bias, based on experience, is I would never want to encourage a wrap-around program. Those who need extra services, I would suggest a different but holistic program.

MS. HODDER: I would say we are watching our managed care program. We have both a for-profit and a non-profit managed care company, so that will be interesting, and they have both been great. So I don't have much more than that to add to the for-profit issue. I think it's a great question.

The FQHCs in New Hampshire are a critical part of our rural health care, and they have

written in cost-based reimbursement into the law through each stage of our Medicaid expansion.

All Medicaid -- I mean, I will admit in this public forum, I feel schizophrenic because we are spending a huge amount of our time implementing our Medicaid managed care and figuring out how that moves into what we call "Step 2," which is long-term care in the developmental disabilities, while we are also planning for premium assistance. And I think there are certain populations that will work very well with premium assistance, and we'll see how far that can go, but we're not quite sure all populations would work well there.

COMMISSIONER ROSENBAUM: So I have to say that I am particularly pleased to see this demonstration playing out because this is what I proposed back in 2009. I felt that it was a far better way to deal with the Medicaid expansion, actually, for a number of reasons, most of all being the salutary effects that it would have on the risk pool, particularly if you used a screener. That most of the people coming in would actually be healthy adults who just happened to not make too much money.

And there are certainly complicated issues to figure out, and you are obviously in the throes of grappling with them. I am hoping that in fact the GAO study does not have the effect of chilling the opportunity for a number of states to come in and attempt premium assistance, because I think we need to know how it works in different markets. Arkansas had no developed Medicaid managed care market, interestingly. Of course, neither did New Hampshire.

It's interesting to see the model in states in which you also have maybe a large Medicaid managed care market migrating into being multi-market plans. I mean, there are a lot of things to test that we will find out from the demos under way, but there are a lot of questions that we won't have answered. And I share your concern that a far too narrow view of budget neutrality has been taken here.

One of the other issues, when I looked at the GAO report -- and I have a couple of questions for you, but one of the issues that I wondered about is, of course, in Medicaid, since 1965, you

could buy private insurance for people. The cost-effectiveness test actually had to do with employer-sponsored coverage. There was never a cost-effectiveness test originally, and the private insurance option sort of migrated in later on.

But when the calculus was done, was there any attempt to say, "Okay. Well, we're just going to do the thing that's an option for us to do. We're going to offer Medicaid beneficiaries private insurance"? And we will have under the state plan amendments -- we have a method for calculating cost effectiveness, so that the comparison of your model against the demo would have been a model in which voluntary private insurance could have been bought, anyway. I would assume that a lot of low-income people would have been very interested in buying a private insurance policy, and I didn't see any evidence that that was factored in.

Did GAO think about that, that you could have done that, anyway, just offered to any Medicaid beneficiary who wanted a private insurance plan?

MR. ALLISON: You know, it would have been interesting had GAO talked to the state, and we might have had this conversation, but they didn't.

COMMISSIONER ROSENBAUM: So I have a couple of questions, though. One is -- sorry. One is I'd love to know what the doctor reaction was and the hospital reaction in the state. I assume there was a combination of joy that in fact the expansion was coming and coming in a private insurance structure, so that the rates would be better, but we're talking about a lot of low-income adults.

Of course, the assumption about low-income adults often has been that it's not just a matter of provider rates, that it's also there are social challenges, health challenges.

Now, you did have the medical screener, but I am wondering, what was the reaction of your state medical societies to the notion of having a couple hundred thousand very poor adults essentially having access to them?

MR. ALLISON: Well, I would say generally favorable, and in a constructive state -- I didn't say this, but you all probably know that we had to get in Arkansas, 75 percent super majorities in both chambers two years in a row for this to happen. So that's a majority of what is a Republican majority in both chambers of our legislature. That was the first time since Reconstruction.

And that dynamic is obviously reflected in the body of those practicing medicine. So this was not an easy decision for the societies to come out in favor, which is the first answer to the question, which is that they did.

It is hard to know what their individual calculus was, because so much of what you have just described, Sara, is unstated and probably never will be stated in public.

COMMISSIONER ROSENBAUM: Except by dentists, as it turns out in the --

[Laughter.]

MR. ALLISON: Well, absolutely.

I'll tell you, though, the private option makes it very difficult to object to the expansion.

COMMISSIONER ROSENBAUM: Yeah. Whether it drives underground something that there's always sort of a foil for, and once you create private insurance --

MR. ALLISON: I think that there was a misconception in the specialist thinking that that meant they actually would get the preexisting commercial rate, and that the carriers wouldn't realize that this is now a blended market, and maybe it should be a blended provider rate. Immediately, after it was adopted, et cetera, the Blues decided to actually implement a blended rate, which created some reaction in the second year. This last spring after it was adopted and had been implemented, they weren't so happy with the 15 percent rate reduction that they got versus the commercial pay, again, a very difficult argument, though, to sort of suggest that the private market doesn't know what it's doing in setting rates for sufficient access.

COMMISSIONER ROSENBAUM: Deborah, my other question, which involves way too long an answer for here, but I'm very, very interested in the issue you raised about both the blending -- and of course, Lucy, you're going through the same thing -- both the blending of the personalities of a Medicaid agency and insurance department, but more specifically, I am really interested in specifically what the state Medicaid agencies and what CMS actually have required as sort of minimum ground rules for their authority over the insurers if they're going to be putting this much money into the pool, so how the MOUs are being structured.

The Medicaid agency is no longer the purchaser. It is obviously a sponsor -- I mean it is a sponsor that is demanding some purchasing rights. So how that gets balanced out, I think is really important.

And to the extent that these MOUs can serve as models, I think it's very important that they get written about and that a fair amount of presentation work gets done, because they're such -- I mean, they're just -- you know, for really good reasons, they're profoundly different.

MS. BACHRACH: Yeah. I think this is an issue that we're working on. I mean the big "we." I think CMS is thinking it through. I think states are thinking it through. I know we are thinking it through, which is what is the Medicaid agency's responsibility in the premium assistance model.

COMMISSIONER ROSENBAUM: It's a sponsor -- that's been rocky between CMCS and CCIIO.

MS. BACHRACH: Absolutely.

COMMISSIONER ROSENBAUM: So, I mean, it's the same. We're seeing it play out federally too.

MS. BACHRACH: But one of the benefits, I think, is that when the ACA plays out -- we all talked about this continuum of coverage across insurance affordability programs, and that's been way

harder than any of us ever thought, with more gaps than we wanted to have at this point.

This is forcing a dialogue that happens that's unbelievably important, which is the best of Medicaid and the best of the private market coming together, and quite frankly, I'm not sure why every small state that's doing Medicaid managed care ought to be looking at it, because as Lucy said, they have two Medicaid managed care plans now in New Hampshire. They used to have three. Two is the minimum. They could have five QHPs. Think about what it means to put it together in terms of options for individuals.

But you've hit the nail on the head. That is really an issue that is still being resolved, and I don't think we can quite jump to any definitive answers yet.

MS. HODDER: Right. We certainly -- I mean, it took us several interagency meetings before we could bring up the concept of the MOUs. So, I mean, we're --

[Laughter.]

MS. HODDER: But we're there. We're there. We're absolutely getting there. How it works out is going to be something that we will be carefully thinking through with our federal partners, because it's very interesting how you come at it from the Medicaid perspective as a purchaser or sponsor, and what that really means in a private insurance market that has not had that kind of relationship ever.

MR. ALLISON: And I think that's a point for MACPAC, as well, which is -- I can just tell you from experience, your Medicaid directors have purchased, and they have these, partly through serious pressure and others -- you know, they are actively purchasing. They've thought about competition. They tried to decide how many MCOs there should be. They tried to decide whether they will put a contract on the table or whether they will compete managed care companies against each other. They've been doing this for years.

Insurance regulators have a different conception of their relationship to the marketplace

because they are providing guidelines to hopefully enable competition, very different, and it's one reason I suggest that MACPAC continue to take an active position in advising Congress on this matter. It's because of that distinction.

COMMISSIONER RILEY: But this area is of great interest to me because it's also the insurance model of competition and negotiation versus the Medicaid model of rate setting.

Now think of a world -- and in my state, we're in that world -- of ACOs and consolidated systems, where all the physicians and all the hospitals are one entity. Insurance competition doesn't work in that environment, does it? I mean, the providers are a monopoly, and the providers set the price. Then don't you need more of the Medicaid skill? I mean, how does competition work then?

MR. ALLISON: It's a terrific question. Arkansas chose not to encourage ACOs for precisely that reason. Our payment reforms, which are, by the way, written right into this legislation and required in the QHPs, not just in Medicaid, are designed around the provider, leaving the organization of care to the marketplace. We incentivized the medical decision-makers and let them decide whether they need to be part of the big system or not, as opposed to saying let's pay the big system to figure out how to be efficient with care.

And one of the core reasons is we are a small market, and it would take maybe two large systems to swallow our entire state, at which point, I as a purchaser have lost my leverage.

MS. BACHRACH: But the leverage goes up when Medicaid and the insurance agency are working together, taking the authority to regulate the QHP or certify the QHP and then Medicaid's longstanding purchaser role, and then you throw in state employees, and you have some pushback against the dominant provider system.

VICE CHAIR SUNDWALL: Okay. Well, thank you so much. You guys have done something unusual. You have kept me awake after lunch, and I normally have the postprandial slump, but

I've been riveted, believe it or not. This is interesting to me because I'm from Utah where we're still in the throes of deciding whether or not to expand, and the Governor got religion last February, about a month into the legislative session, a little bit too late. But we actually hope to get a waiver in next month, is what he's hoping for.

And it seems like -- this has really been informative for me because I think you've done a lot of the groundwork in anticipation.

I'm surprised New Hampshire has done so much infrastructure or work on this and you're not expecting the waiver until next March? So I think you're way ahead of the game on us, but we, nonetheless, are trying to get that authority to move ahead with premium assistance and a little sticking point on a work requirement, which they're still working out.

But, Deborah, have you consulted with folks in Utah?

MS. BACHRACH: Not in a while, no.

VICE CHAIR SUNDWALL: Because, clearly, we'd benefit from your rich experience and your wisdom on this, but anyhow I just --

MS. BACHRACH: Not yet.

[Laughter.]

MS. BACHRACH: Thank you, Lucky.

VICE CHAIR SUNDWALL: I think I will be your agent and get you out there.

But anyhow, the point is I resonate with a lot of what you said. I think it's great. I think the brightest thing I heard, because I've always been troubled by the supplemental payments, and the fact that if we went this way, we could do away with what I call "supplemental shenanigans," which are all over the place and trouble me. I know Patty thinks they are essential, but if we had something like this that gave people access and better payment to providers, we may just be able to put that kind of complicated,

costly process behind us.

So thank you very much. It's very informative, and I am enthusiastic about seeing how this plays out.

COMMISSIONER MOORE: Thank you. This is really, really interesting and helpful and something that I think the Commissioner has to continue to follow for several years, if not more.

I want to step back a minute, and I know Deborah and Andy -- and I don't know about Lucy -- have a long interest in Medicaid and a long history with 1115s, and I'd like for you to think in the 1115 demonstration kind of thought process for a minute, because that's really what we're talking about here.

And there's been lots and lots of controversy over many, many years, going back to Arizona and the '80s, over whether this is the right thing to do in Medicaid, and I think some things like GAO reports come along and ring people's bells, and it becomes very politically sensitive. I know that's happening here and in many states.

But in the context of demonstrating and evaluating, how would you look at these experiments in a longer history of the Medicaid program?

MR. ALLISON: I have a strong viewpoint on that, and it is that the role of the federal government should foremost be to collect very good data, not only about the outcomes -- in this case, let's say premiums, ultimately encounter data, et cetera, claims -- across states to enable a meaty evaluation and investigation, prospective and retrospective, of how things have turned out, but also very good data on the policy variation.

That's one of the things MACPAC has begun to contribute to, but it's so difficult for a Medicaid director to find out what another state has done according to state plan and contract with the federal government in a way that's easily searchable. But you could turn that around, and you have a

record of what each state has done over time in this area and that area, and if they don't all do the same thing at the same time, you've just scientifically, statistically identified the outcome, if you have both.

Collect the data. You will have 50 earth-shaking Ph.D.'s written to give you the answer.

CHAIR ROWLAND: Given that, could you speak to 1115s have historically always, supposedly, had a strong evaluation component? What evaluation activities are actually in place for these demonstrations?

MR. ALLISON: Let me see how I should say this. So, full disclosure, my first professional job was at OMB reviewing 1115 waivers for budget neutrality. That's what I did for the first three years, here in D.C. When GAO wrote its first report on budget neutrality, they didn't talk to me then, either.

Look, there are real challenges with budget neutrality. There's no question. How you establish a hypothetical alternative universe of what would have happened over the ten years or five years in the state is essentially impossible.

Conversely, if you don't allow states to investigate, you won't ever learn anything.

So the question was budget neutrality.

CHAIR ROWLAND: The question isn't really budget neutrality. It is really evaluating the demonstration.

MR. ALLISON: The answer is I don't actually think the evaluations have ever been very strong for precisely that reason, because the data used to demonstrate what are 1115s, specifically a statewide experiment, well, you've just lost your comparison group.

Again, I think the answer to this isn't states evaluating themselves. It's good data at the 50-state level, and in that respect, Judge Roberts just created the perfect natural experiment.

The delays in some states to adopt premium assistance or to do it in different ways just

established statistical identification of the outcome, two, three, four years from now. That's what I think the answer to evaluation is.

CHAIR ROWLAND: What about evaluating the impact on the beneficiary?

MR. ALLISON: That's what I mean in fact.

So how do we know what the impact of -- so what is our experiment? Our experiment isn't expansion so much, although will contribute to the results on expansion. It's really expansion through the private option, which is identified by comparing ourselves to those who expanded in some other way. The outcomes are all at the beneficiary level and aggregate up to the population.

Do they have the same level of access? Do they obtain the same primary care and preventive care at the same rate? What are the outcomes for chronic? The outcomes are from the claims in each -- and the encounters and maybe other data in every mortality across states. That's the outcome, and it is all about the beneficiary.

MS. BACHRACH: And it very much is in the Arkansas waiver. The negotiation with CMS and AHRQ was at the table in constructing the evaluation plan, and because Arkansas has a Surgeon General who works out of that institute, whatever -- I can't ever get their -- you know, there were clinicians and researchers on the phone with CMS, with AHRQ, looking at every single hypothesis and where was the data to test it, including can beneficiaries access the benefits that were being provided fee-for-service, EPSDT too, which -- non-emergency medical transportation.

So I think that this is one of the most rigorous evaluation plans that I'm aware of, and it was a tough, tough negotiation.

MR. ALLISON: It's a combination. So it will be ACHI with external advisors. In fact, I'm not external. I'll be talking with them Tuesday.

But again, what I really believe is that the most powerful examinations will be those that take

a look across 50 states, and in our case, it won't actually just be a look at Medicaid. It will be a look at the QHP rate trajectory and level of competition, measured not by the number of competitors, but let's say the Herfindahl Index for concentration in states like us, Mississippi, Alabama, Georgia. That's ultimately the test, and it isn't just Medicaid.

And that makes it very hard at the scale of an 1115 evaluation for the state. These things are costly. The data is all federal to begin with. It's multi-agency.

MS. HODDER: And I don't have a lot to say on past practice and 1115 waivers, so I'll leave it to them.

But I will say that leaving the states all of the responsibility on the data collection and evaluation is a tough one. We can do what we can, but accessing the data across states is very difficult.

And an interesting comparison is also what's happening not just to the zero to 138, but the 138 to 400, the 400 -- it is over the spectrum of coverage that will be very interesting, given the multiple experiments that we are all engaging in at the same time.

CHAIR ROWLAND: Mark.

COMMISSIONER HOYT: I just wondered if Arkansas had any feel for what percentage of the eligible pool declared themselves to be medically frail, and is New Hampshire going to follow the same methodology of kind of raising your hand?

MR. ALLISON: Yes. We tracked that on a daily basis, up until the end of May, and it's interesting.

So this is a population-based survey. It's actually a universal survey. When we have that sort of perfect meld with HealthCare.gov and between our eligibility system and our own health plan selection platform, we will have 100 percent participation in that screener.

Right now, we don't, so we have -- it's over 50. I think it's closer to 60-plus percent who

are at this point taking the screener. Of those who take it, the rate that blow high and are medically frail, is actually well into the teens. It's closer to 20 percent than 10 percent. The net of those two is right around 10 or 11 percent, which was the policy target for year one. Again, we had the obligation of going first, had no idea how many should be medically frail, had to identify them prospectively. So we determined the outcome. We said it would be 10 percent, because we figured that was higher than it actually was. We wouldn't miss anybody.

Over time, we think that probably will go down, and we're kind of hearing that from both sides. From the insurance companies, they've stopped complaining about high-cost individuals, and we are really not getting complaints from individuals if they are in the wrong place, unless it's Medicaid and not in the QHP.

COMMISSIONER GABOW: A number of times, the construct of personal responsibility came up, and I am assuming that that means premium support and copayments and rather -- and life choices.

But I had raised earlier today, when you look at the premium and co-pays from the provider perspective and from the administration of the state, is the juice worth the squeeze, meaning one dollar for a prescription for a provider, the amount of administrative structure that you put in place for that dollar, which you often then waive because they don't have the buck, and the same way with premiums.

So is this -- do we really know if the juice is worth the squeeze for the --

MR. ALLISON: Coverage is worth the squeeze. And if that's what it takes to get the vote -- I mean, just plainly, this is -- honestly, it is worth the squeeze if that's what it takes to get someone covered, because that's what it takes to get the vote to get someone covered.

MS. HODDER: Right, and I would just add to that there is the concept -- I would agree wholeheartedly with what Andy said, and we're dealing with this issue right now. So we're right in the

throes of it. The concept was also that we should be educating everybody on how to have private insurance, so that eventually they will be able to access coverage through the marketplace as they move into other income levels in a way that's accessible and they understand and they're used to. So the concept was to start with small co-pays, and as you do better in the world and have access to income, then you will do more.

So I don't know if that will work. I really don't know. But that was one of the concepts that was used politically and rationally in arguing that there should be personal responsibility. We're still trying to figure out where that balance is, in all honesty.

MS. BACHRACH: Without making a value judgment, I think that when -- in operationalizing the premium assistance, if you look at the folks above 100 percent of the FPL and they move into a 94 percent AV plan, you can construct a 94 percent AV plan consistent with Medicaid cost-sharing rules. And Arkansas did that; I suspect New Hampshire will do the same. So Medicaid pays the premium. Medicaid pays the deductible. But the cost sharing, the co-payment at point of service can come in within Medicaid guidelines.

One might argue, as I think where Lucy was going, that if the 100 to 138 percent have a co-payment that is very consistent with what they would see at 140 percent but no deductible, you can sort of see it moving up the scale. Whether that's a good thing or bad thing, I don't know, but it was interesting to me that the 94 percent AV plan is more or less consistent with Medicaid rules.

MS. HODDER: The one other thing that we are grappling with and we don't have a solution to is how you deal with the ER problem and use of the ER, and really making that an efficient system now that coverage is available is something we're really struggling with. And it does come into play with whether a co-pay works or doesn't work, non-emergency use, et cetera.

CHAIR ROWLAND: You know, we spent most of the morning talking about the CHIP

program and the future of the CHIP program. So just before you leave, could we squeeze one more question in about how have you envisioned CHIP or how is it planned to work with your premium assistance? How do you see that transition?

MS. HODDER: You know, I am not the Medicaid director in New Hampshire. I am the lawyer for the governor, so I need to approach this tepidly. My understanding is that we have a CHIP program that's very well balanced, very well utilized. It works extremely well, and we don't want to threaten it.

MR. ALLISON: Arkansas built into its legislation a requirement for the state to investigate, pursue, and propose, but not necessarily succeed -- which we had to succeed in everything else, like you all do -- in blending, in integrating the children with their families into qualified health plans at a later date. And so Arkansas' waiver the last three years, that's to coincide with the inauguration of the Section 1332 authority in 2017 and beyond when this question will come up -- for that time period this question will come up.

It's difficult, it's thorny. I think, you know, it goes right to the heart of questions about wrap-around, and what EPSDT really means practically on the ground if you have rehab now in the basic benefits, whether you're wrapping with the program, whether you're taking individual children who need more and serving them in a different program, the idea is that we'll learn enough from the first couple of years of the private option to help provide some assurance that if the children are moved in, you know, that it's to their benefit and not to their detriment. You all have identified some of the cost issues and transition issues associated with that.

You know, Medicaid is going to have to manage the margin now that we have in many states universal coverage. And so we now have an obligation to deal with churn and the complexity of multiple plans within a family. Hopefully in the next couple of years, we'll start to have some awareness and learn

something from the data about if -- you know, whether the premium assistance solution really reduces those costs and, therefore, can be balanced against the perceived protections of the CHIP program.

MS. BACHRACH: I have one state that's looking at voluntary premium assistance for their CHIP kids as a potential mechanism to keep families together. And if they decide to go forward with that, I think it would be an interesting -- it would be interesting to see how that works. But it would be voluntary with the goal of whole family coverage.

CHAIR ROWLAND: Well, we certainly thank you for all of the wisdom that you've squeezed into the time we've given you, and I hope Patty got a lot of juice out of it, to keep with that phrase. But also, if there are ways that you can help inform our deliberations around the CHIP program as well, we would appreciate any of your thoughts, since clearly what we're trying to look at is how to have a continuum of care that works for the entire population that depends today on Medicaid and CHIP or that is newly going to be insured.

So thank you very much, and with that we'll take a brief break.

[Recess.]

CHAIR ROWLAND: Okay. If we could reconvene, please. If April and Martha could join us?

We've all been concerned about what the impact of the Affordable Care Act and some of the Medicaid expansions are. We know there's no one reliable, total, new data set that can answer that question. But as always, we're going to ask April and Martha, who is joining her, to tell us what we can know, even though we have no perfect answer.

SESSION 3:

UPDATE ON MEDICAID AND CHIP ENROLLMENT IN 2014

* MS. GRADY: Thank you. Good afternoon. As Diane said, we're here to tell you today

about what we know about Medicaid and CHIP enrollment in 2014 and just a brief overview of what we're going to talk about today.

We'll discuss the importance of data for policy issues related to ACA implementation, which, you know, all of you are familiar with at this point. I'll talk a little bit about the recent increases in the number of people who are enrolled in Medicaid and CHIP, and Martha will give us most of the early findings on changes in coverage rates, the demographic and health profile of Medicaid and CHIP enrollees this year, and access to care and use of services in the programs.

Okay. So, of course, we know that data provide context for everything that we do here, and in particular, related to ACA implementation, there are a number of issues that we'll be looking at. Of course, an important one is beneficiary experiences and access to care, and that may be affected by a number of factors, and the issues may include affordability, benefit package generosity, and the availability of providers, all of these things that affect the beneficiary experience. And going forward, survey data will be able to give us a sense of whether enrollees are having difficulty paying for care or accessing certain services. And, in addition, both the survey and the administrative data will allow us to examine changes in service utilization.

Of course, state and federal budgets are a concern for everyone, and administrative data on the increased Medicaid enrollment among the newly and previously eligible can help to assess the financial impact of expansion and non-expansion decisions.

Data also inform policies that affect providers. For example, survey data on coverage changes will help to inform the impact of the forthcoming payment reductions to hospitals that serve large numbers of low-income and uninsured individuals. And you'll be hearing more about that from Jim Teisl tomorrow, and those payment reductions, of course, are based in part on states' uninsured rates.

As you know, the vast majority of Medicaid and CHIP beneficiaries will be enrolled in

managed care plans -- new Medicaid and CHIP beneficiaries will be enrolled in managed care plans along with a large portion of the existing population. And using federal administrative data on managed care enrollment encounter data, it will be possible to examine changes in the composition and the service use of the managed care population with this new influx, as well as make comparisons to the fee-for-service Medicaid population. And you'll see from our presentation that we have basic information now but that detailed data won't be available until 2015 and beyond for the most part.

Of course, this is probably not news to you that CMS reports an overall 12 percent increase in Medicaid and CHIP enrollment for June 2014 compared to the July-September 2013 period last year, which was prior to the open enrollment period for exchanges that began in October, and the Medicaid expansions that began in many states in January of this year.

Of course, there is a difference in the growth rates for expansion and non-expansion states. I'll just flip right ahead to this chart here. There's a lot going on, but the first thing we see, of course, is the difference between expansion states, which are on the left side, and non-expansion states, which are on the right side. Although the performance indicator data on which this chart is based -- I'll talk a little bit more about those performance indicator data on the next slide -- although the data don't separate out newly eligible and previously eligible enrollees, the growth rates for non-expansion states that are on the right side here suggest that a number of previously eligible individuals are getting coverage. Because there was no expansion in those states, most of the enrollment increase that we see would be due to what's commonly referred to as the "welcome mat" or the "woodwork" effect.

One other thing you see here is that there's also variation among the states within the expansion and the non-expansion groups here, and there are a lot of factors at play, of course, in terms of where an individual state lands with regard to its growth over the past year.

One of the factors is their previous adult coverage levels, and states that previously covered

at least some or a large number of childless adults, we're going to see lower growth rates. And those that didn't cover anyone and perhaps had pretty low coverage levels for parents, we might see much higher growth rates.

There are a handful of states that rolled back coverage to the mandatory minimums for parents, for example, and that would affect the rates that we see here. Take-up rates, of course, among the newly eligible and the previously eligible populations, states have employed a number of outreach strategies to try and reach people who are eligible for the program, and those policies may have an effect on these numbers.

And, of course, my favorite factor -- or not, as the case may be -- are data anomalies, and so there's just a couple of things that I want to point out here. CMS has worked hard with states and gone back and forth to get the best information they can, but, you know, sometimes questions remain about the numbers that we have from particular states. And I'll just call out a couple of examples here so that you don't focus too much on the particular point estimates. But the general magnitude of the change for a specific may be important.

Georgia is an example where, you know, they're at the top for the non-expansion states. The CMS data show 16 percent growth in their program over the past year. But in a recent news release, the state says that their enrollment growth has actually been more like 6 percent, and they're not sure why the CMS report says 16. So there are some things to be worked out.

Similarly, among the non-expansion states, Alabama is showing an enrollment decrease, but that is possibly because their current enrollment data don't include Medicaid expansion CHIP enrollees that have recently transitioned from their separate program to Medicaid as a result of the stair-step transition.

So I just say this to point out that there may be things going on here, so don't focus too much on any particular state's number.

VICE CHAIR SUNDWALL: Maine isn't -- they don't have data for Maine, but it's your impression that you've actually had a decline in enrollment in Medicaid?

COMMISSIONER RILEY: No [off microphone].

VICE CHAIR SUNDWALL: You don't know because the data is not there? You said it this morning. I just was going to --

COMMISSIONER RILEY: [off microphone].

VICE CHAIR SUNDWALL: Uninsured.

MS. GRADY: The other thing I'll point out here is that New Hampshire and Pennsylvania both show up in the non-expansion category, but, of course, New Hampshire you just heard from in the previous session is expanding their program, and that's effective -- it was effective in August, I believe. And Pennsylvania's expansion will be effective in January of next year, so right now they're in the non-expansion column for June of 2014, but they will soon be moving over.

So despite these big numbers, Medicaid and CHIP enrollment growth in the most recent months, May and June, has slowed to about 1 percent or less in most states, and that's perhaps due to the end of open enrollment for exchange plans, sort of this initial push to get people in the program. But I will note that we expect enrollment to increase in some states going forward, particularly in states that have had large application backlogs, and CMS has been in touch with I believe it's 13 states about their backlogs and how to resolve those going forward.

Okay. So I've already sort of gotten to the punch line here on the big enrollment increases, but now I want to talk a little bit about the data we have or we will have soon to give us information on the characteristics of the new beneficiaries who are enrolling in Medicaid and CHIP. And before I get into the particular details of these data sources, one thing I want to point out is that we have much more timely information on Medicaid and CHIP enrollment than ever before.

You'll notice on the last slide that I was able to tell you what was happening in Medicaid two months ago rather than two years or more ago. So this is certainly a major improvement, regardless of what other anomalies or other questions we may have about the data.

So as I mentioned, the chart I just showed you is from a new CMS data source that collects performance indicator information from states, and one of those performance indicators is about enrollment. As I mentioned, these data are very timely. The tradeoff is that they don't provide a whole lot of detail on the population. As far as we know, the only level of detail on the characteristics of enrollees is child versus adult and whether you came into the program with a modified adjusted gross income eligibility determination or whether you're under the old rules. And the people who are under the old rules are mostly people whose eligibility is based either on their age, 65 and up, or on the basis of a disability.

Of course, we can separate out Medicaid and CHIP enrollment, though generally CMS has been reporting those two numbers together and looking at the increases. As I mentioned, there's a brief time lag for the availability of these data, only about one or two months.

Another new source that we have not talked about before is what we're calling the CMS 64 enrollment data in the middle of this slide here. It's a really catchy name, I know, but it's related to the fact that states submit this enrollment data at the same time that they submit their CMS 64 expenditure reports, which you are familiar with. They're the source for most of the Medicaid spending information that we report here to the Commission.

Those expenditure reports allow states to draw down federal dollars for the Medicaid program, and CMS is still working with states to obtain and verify the CMS 64 enrollment information. The value added here and the reason that CMS went to this data collection effort is that it will tell us about enrollment by specific eligibility group and, in particular, who is newly eligible and, therefore, eligible for 100

percent FMAP and who is a previously eligible enrollee. Right now, the newly eligible FMAP stands at 100 percent, but as you know, that will eventually phase down to 90 percent.

We've done some preliminary analysis of that CMS 64 enrollment data, and what that shows is that the new adult group in Medicaid in expansion states is about 15 percent of their total Medicaid enrollment right now. So that doesn't mean that it's 15 percent of their expenditures because, on average, these are lower-cost individuals. And it doesn't mean that 15 percent of their program is getting 100 percent FMAP, because what you see in a lot of states that had previously expanded was that, you know, there were people on the program already, so their newly eligible increment or the number of people that are coming on at 100 percent FMAP is not that big. The people who were already on -- the childless adults who were on their programs already -- will get a higher FMAP but not 100 percent.

The other source we have listed here is the Transformed Medicaid Statistical Information System, or T-MSIS. You've heard a lot about MSIS. Again, this is one of the main data sources we use to report information to you. It provides detailed Medicaid eligibility and service use data, and information on separate CHIP enrollees at state option. And that goes back to fiscal year 1999, to the present year. And right now there's a considerable time lag in getting information from MSIS. It has to come from the state to CMS. It has to go through a processing series of edits. Then it gets reported to us. And so it takes quite a long time to make its way into the world.

CMS has committed to much shorter time lags for the Transformed MSIS system. The original plan for T-MSIS was to have that rolled out in July of this year. CMS has pushed that deadline or that goal back to January of next year. It's our understanding that there are a large number of states that have been testing this and are in a position to be submitting T-MSIS files by the end of this year, but that sort of remains to be seen, and we'll keep you posted on that, as we know more.

The other source of information that I'll just talk briefly about are reports from the states.

Of course, states are releasing data on their programs, but they don't always provide details on the new adult population in Medicaid or a clear comparison to previously eligible or enrolled populations. So we don't necessarily have a profile of those enrollees from the state reports.

Most of what we know about health status is anecdotal, and it generally is sourced from the managed care plans that are covering the new adult population. And there's sort of a range of experiences that we're seeing reported here. One example from Massachusetts. The plans that are covering the new adult population say that the beneficiaries are older, have more health conditions than their previous enrollees. On the other hand, Arkansas, which is enrolling, as you heard, nearly all of its adults into exchange plans, is finding that those enrollees are younger on average than their remaining exchange population. So it sort of depends on what you're comparing it to, first of all. Are we looking at the new adult population relative to the old Medicaid adult population? Are we looking at it relative to the exchange population? So there's just sort of not a lot of clear information yet on the health status of this population.

Both the Congressional Budget Office and CMS have projected that, on average, the new adult population will be healthier and lower cost than the previously eligible adult population, but, again, we're waiting for the actual data to see whether that's been borne out.

Okay. So now I'm going to turn it over to Martha for information on what we know from survey data.

* MS. HEBERLEIN: So beyond the impact on Medicaid, we also want to know what impact the ACA is having on coverage more generally. And, you know, this will be the cumulative effect of both the Medicaid expansion, the woodwork or welcome mat effect of already eligible Medicaid beneficiaries, as well as exchange enrollment and increases in employer-sponsored coverage. And all of those things together are really expected to drive down the rate of uninsurance. But really to assess this,

we need to look at survey data.

So over the next few years, a number of surveys, both federal and private, will be fielded. That will give us more data on coverage changes following implementation. The surveys will provide data on changes in coverage as well as, depending upon the source, I should say, there may be additional information regarding coverage type, access and utilization of care, as well as some demographic characteristics of the newly covered.

So federal surveys are by far the most common source of health coverage data. They have the benefit of large sample sizes, higher response rates, and longer historical trends. Their robust data allows for a subnational analysis, so looking at states or other groups of interest. But there's a lag in these data, and in most cases they won't be available until 2015. So at this point, there's a number of private surveys that have sort of been providing us this initial look at what the ACA has done for coverage, and they include the Health Reform Monitoring Survey that's done by the Urban Institute, the Gallup-Healthways Well-Being Index, the RAND Health Reform Opinion Study, and the Commonwealth Fund Affordable Care Act Tracking Survey.

And so far what we've seen from those is that the results are pretty consistent. There's been a decline in the uninsured and an increase in Medicaid coverage for adults seen across the surveys. And it's important to note that the differences in the point estimates and the magnitude of the change reflect several factors, including the survey design, is it an Internet or phone-based survey, you know, variations in the sample of who they're actually talking to, as well as inconsistencies in terms of the time periods that they examined.

So as you can see from this slide, the most recent estimates available suggest a decline in the rate of uninsured adults ranges between 3.7 and 5 percentage points. And at the same time, the rate of Medicaid coverage has seen an increase of 1.5 to 1.8 percentage points. And similar to what we saw with

the enrollment data, states that have chosen to implement the Medicaid expansion have seen a larger decline in the uninsured and a greater increase in the number reporting Medicaid coverage than those who have chosen not to expand.

So the data are still fairly limited in terms of who has secured coverage as a result of the ACA's expansions, and typically they're more reflective of who is newly insured and not who's newly covered under Medicaid or who's newly covered under marketplace coverage. It's really just who's now covered.

There are some cases where they do break down the data by income level so for -- you know, where you can get sort of an approximate of Medicaid population. And the gains have really been seen across all coverage -- excuse me, all demographic groups, but the specifics in terms of race and ethnicity as well as gender and age differ depending upon which data source you're looking at.

One point of consistency, however, is that when reported, the data all show that those with lower incomes have seen particularly large improvements in coverage. So, as April alluded to, the implications for cost and access to care also make health status a very important indicator for state and federal policy makers.

So, at this point, little is known, but one survey has found that among individuals with income at or below 138 percent of the FPL who have gained coverage since open enrollment, the newly insured are less likely to report poor health than those who have had coverage all year.

There are also a few data sources that give us a sense of whether the newly insured are actually accessing their coverage. So, again, this is not available by coverage source, but it shows that 60 percent of newly insured adults reported that they had used their coverage for either a doctor visit or a visit to a hospital or to refill a prescription. And, of those, a majority actually reports that they would not have been able to access that care before securing coverage.

More adults also report having a personal physician and fewer report having difficulty paying for care, and this is significant, as another survey has found that the newly insured are also shown to be unattached to the health care system. So, almost half did not have a usual, or have a routine check-up within the past year, and more than a third have not had a usual source of care.

So, there are concerns that there's pent-up demand for services by the uninsured that could lead to access issues, but as of yet, there has not been an overall increase in new patient visits -- patients seen by providers. However, the data do show that in states expanding Medicaid, providers were already seeing a greater share of beneficiaries compared to states that didn't expand, and that disparity has continued after open enrollment.

So, as mentioned earlier, there are a number of surveys that will be fielded in the next few years that will give us more data on coverage changes following implementation of the ACA. The federal surveys will provide us the most comprehensive data, but, again, these are delayed. The earliest of these actually came out on Tuesday, and that's the early release from the National Health Interview Survey, and it looked at the first quarter of 2014 and compared it with 2013, and the results are very similar to what we've seen in the private surveys.

There was a significant decrease in the percentage of adults who were uninsured at the time of the interview, and while there was no significant change overall in the percentage of people with public coverage, in states that had expanded Medicaid, there was a significant decrease in the rate of uninsurance, while those that have not expanded Medicaid did not see such a decrease. And then, in addition, adults in expansion states were more likely to report public coverage than those in non-expansion states.

So, the data do not provide any further details on Medicaid. It's just a public-private-uninsured break. But, MACPAC has been able to get more comprehensive data out of the NHIS from the National Center for Health Statistics, but that's really -- obtaining these data is really subject

to their staffing and resource constraints, so --

But, beyond this early look, we will be waiting until next year to get more details on coverage. The full NHIS will come out in June, and then that will be followed by the American Community Survey and the Current Population Survey, which will be released in September of 2015. And then, further on, the Survey of Income and Program Participation and the MEPS, Medical Expenditure Panel Survey, will both come in 2016. So, there will certainly be lots more data to come and we will share updates as we get those.

CHAIR ROWLAND: You know, I think one of the very important things to look at in this data is not only -- there's been a lot of focus on how many people got coverage through the exchange and how many individuals got coverage through Medicaid, but in many of the surveys, you're seeing an increase in employer-based coverage, too, and I think it's important to look at all sources of coverage and not to just focus on those going through Medicaid or the exchange.

The other thing is, of course, that so many people were shocked that so many of the newly covered were being enrolled into Medicaid instead of into exchange-based coverage, and as we all know, the poorer you are, the more likely you were to be able to get coverage through Medicaid now than through the exchange.

Other questions or comments? Patty's going to ask why it takes so long to get this data. No. Sara.

COMMISSIONER ROSENBAUM: To your point, Diane, and as we do the data, I think one of the things that is incredibly important for us to do -- I find that it's just this constant level of shock among people -- it was Patty's point this morning, and I, you know, have this every time I speak -- Americans have no concept of how poor people are in this country. They really don't. And, so, when -- the more we can show people in our data that the numbers fall out the way they do, because if you map the

newly insured against the income distribution of Americans and the demographics of who is likely to be uninsured, and then if you take the esoteric MAGI formula and explain sort of in English how it works, that you're actually dealing with people who are making, you know, in some cases, potentially almost twice the minimum wage in a larger family and their income is below the cutoff.

And, I just -- I just think we have -- it's one of the ways, the most powerful ways we have to explain Medicaid's role is, ironically, not just saying it does these things, but this is the percentage of the American population that is actually eligible, that is below the threshold, is too poor for subsidized private insurance. And, so, when we think about displays, I would just recommend a display that maps the two facts against each other.

COMMISSIONER RILEY: I have sort of an academic interest that maybe -- in how many people may have lost Medicaid because of MAGI. How many states had more aggressive disregard systems, and when MAGI went into effect, did people actually drop off Medicaid? And I'd like --

COMMISSIONER ROSENBAUM: [Off microphone.] COMMISSIONER RILEY: Did they [inaudible]? I don't think so, did they?

COMMISSIONER ROSENBAUM: I would think there are certain kinds of people who really -- I mean, especially people in homes with special needs --

COMMISSIONER RILEY: Yeah, and some states were very creative with the disregards and --

COMMISSIONER ROSENBAUM: I don't think there was a -- but it would be good to know.

COMMISSIONER RILEY: It'd be interesting to know --

COMMISSIONER ROSENBAUM: Yeah.

COMMISSIONER RILEY: -- because I think it's an important provision.

And, secondly, I can't help myself. It's great to see this new -- CMS has done a wonderful job getting us data that's two months old. That's shocking. It's great. But, do you have a sense of why the three states who didn't submit, what the problems are in those three states?

MS. GRADY: I honestly don't know. Maine, I believe, was able to report partial information, so their new enrollments were available, but the total population was not, for some reason. I do not know about Connecticut and North Dakota in particular.

CHAIR ROWLAND: I mean, in that vein, perhaps it would be worthwhile for us to think about what information we would like to tell CMS that we think is important to have in our deliberations and for others, because there is a great deal of confusion about what's in the numbers, what's not in the numbers, and, really, just kind of laying out if we got an ideal set of information from CMS based on what they're collecting from the states, what would it be.

Denise.

COMMISSIONER HENNING: I'm sort of playing off Sara's point. Then, I'm kind of wondering, this doesn't happen in a vacuum. So, we've also got an improving economy underlying some of these things, so maybe they no longer qualify for Medicaid because they actually have a job with employer-sponsored insurance. So, that's got to affect some of these rates in some way, and I'm not sure how you quantify that. I guess that's you guys' job.

CHAIR ROWLAND: Well, it was interesting with the Census numbers that came out for 2013, and everyone was saying, well, why did the number of uninsured go down, not to mention that the Census changed its way of counting things. But, obviously, changes in the economy are key indicators of what happens to Medicaid numbers, with or without the Affordable Care Act. And, so, it's very hard to tease out the cause and effect of what changes some of these numbers. But, we'll leave April and Martha to try to do that.

Other comments? Patty? Trish? Mark?

[No response.]

CHAIR ROWLAND: Okay. Thank you very much.

Now, we're going to move to program integrity.

[Pause.]

SESSION 4:

REVIEW OF CMS PROGRAM INTEGRITY PLAN

* MS. FORBES: All right. Sorry. Good afternoon, again. I'm not sure what I did to Anne to get program integrity to be the end of a packed day, but I got -- I got real fired up about this memo when it came up this summer, so, hopefully, I can convey a little bit of that to you.

In this session, we're going to talk about the new Comprehensive Medicaid Integrity Plan that was released by the Center for Program Integrity at CMS this summer. In your background materials, there's a memo describing the contents of the plan in a little more detail and a comparison to some MACPAC recommendations. We've also provided our assessment of the anticipated effectiveness of the plan, and we'll discuss that further in this session, but what would be helpful to get from you is feedback on any areas you think we should pursue further and any action or follow-up that you think that the Commission might want to take in regards to this plan.

So, as a little bit of background on why I think it's important for the Commission to be talking about this plan today. Congress established the Medicaid Integrity Program in 2006, and it was originally envisioned as being a very provider fraud-focused endeavor. And, Congress also required CMS to produce a five-year plan for how the agency was going to address Medicaid fraud, waste, and abuse beginning in 2006.

The plan was intended to address primarily fraud. Congress actually specifically said that

they should include -- they should consult with the Attorney General, the FBI, the OIG, state fraud control units, and so on in developing that plan.

CMS did develop a plan in 2006. They weren't required to update it every year, but they did for several years. The last update was in 2009 and that went through 2014, and they just this summer released a new plan that covers the period from fiscal year 2014 through fiscal year 2018.

During that period when the last plan was in effect, there was a lot of criticism. As CMS ramped up its program integrity activities, they got a lot of push-back from MACPAC and others. We noted several challenges in our March 2012 report to the Congress, including a lack of good data for proactive identification of fraud and abuse, overlapping and duplicative requirements, poor coordination between CMS and the states, and gaps in terms of things like program integrity for Medicaid managed care. The National Association of Medicaid Directors and the GAO also issued several reports that were very critical of the federal Medicaid integrity strategy.

This new plan, I think, effectively addresses a lot of those concerns. The introduction and executive summary in the plan itself describe a new approach. It's a much broader approach to strengthen program integrity for Medicaid. It goes well beyond fee-for-service and it addresses things like managed care, eligibility, Medicare and Medicaid interactions, and state claiming. Instead of coordinating mainly with law enforcement, they actually reached out to other agencies within CMS responsible for program oversight, including the Center for Medicaid and CHIP Services, the Office of Financial Management, the regional offices, the Federal Coordinated Health Care Office. So, I think it more accurately reflects sort of the federal Medicaid enterprise.

When the plan gets into what they're actually going to do is when I think it falls short of being what we need to understand what CMS actually plans to execute. So, we can -- I'll quickly walk through the activities. There's a summary in the memo. And, then, we can talk about what we think they

might do about that.

So, the first group of activities relates to data, specifically improving the ability of states and CMS to better leverage program data to detect and prevent improper payments, and the plan describes three specific activities related to data.

The first is to complete the state migration to T-MSIS. April just talked about it in the last session. Their original deadline for that was this July. That's come and gone. But, they're working towards now January, and a lot of this plan really depends on having a complete Medicaid data set, so that's obviously a critical activity for them and one that they describe at length.

They're going to create more processes for states to get access to Medicare data and share, you know, linked to Medicare and Medicaid provider and beneficiary and claims data sets so that states can do work that they've been asking for several years.

And, CMS is also going to take the expertise that it's been developing in terms of predictive modeling technologies in the Medicare program and use that expertise to provide training and TA to the states so that they can implement more predictive analytics, which Congress actually requires CMS to do, to work with Medicaid on that.

The second group of activities is around building state capacity, something we've talked about here at the Commission. State Medicaid programs and CMS share responsibility for Medicaid program integrity, and so the comprehensive plan includes a number of activities designed to help build state capacity. Some of those activities are actually around reducing federal activities that the states find burdensome and annoying. Some of the activities are more around providing training and technical assistance for the states in some areas that they haven't covered before, such as managed care and predictive analytics.

The third and largest group of activities relates to expanding CMS's capacity, interestingly,

both to protect the integrity of the Medicaid program and to manage its own risk in the administration of state claiming. Obviously, CMS doesn't pay Medicaid claims. It does pay states. So, that is something that they address in the federal Medicaid Integrity Program now.

So, the plan describes in detail their new effort to re-procure the federal contractors that provide audit support, so they'll have combined Medicare and Medicaid contracts, and the contractors will be instructed to support the states instead of duplicating state efforts.

CMS also plans to conduct more detailed reviews of managed care contracts and managed care rate setting, since that is so much of the spending in Medicaid now goes through managed care. They're going to expand their assessment of state claims processing systems. I don't know much more about that, but there are a lot more rules around how claims need to be processed, coding rules and things like that. So, they'll be doing audits on that. And, they'll be implementing the new annual upper payment limit reporting requirements.

Other activities include testing the new eligibility systems to make sure that eligibility determinations are being made appropriately and that renewals are being processed appropriately. Strengthen the review of state claiming, particularly where expenditures are being matched at 100 percent state -- 100 percent federal funds, and where the state share is being generated through provider taxes or through IGTs.

They're going to be developing frameworks to strengthen program integrity for new forms of payment and new delivery systems that are far from fee-for-service, so that includes ACOs, help homes, the duals demos. Where they have a new payment system, there needs to be a corresponding new way to make sure that those payments are being made accurately. And, they will be pilot testing new error rate measurement methodologies.

So, they noted in the direction to the plan, they patted themselves on the back for taking

into account recommendations made by MACPAC as well as many others, including the OIG, the GAO, and the National Association of Medicaid Directors, all of whom, as I said, have issued many reports sort of questioning the efficacy of the old plan.

We have actually made a lot of recommendations that are somewhat reflected in the plan. In addition to the program integrity related recommendations we made in March 2012, we, in March -- I'm sorry, it was June last year, June 2013, we had a data chapter where we talked about the importance of getting the T-MSIS data set moved along. In March 2014, we talked about the eligibility pilots and the need to develop a new eligibility program integrity framework. So, those things are reflected in this plan.

But, when I read it, when you actually get into the meat of the activities, they don't really get at the full sort of meat of our recommendation, and I can give you a couple of examples.

A lot of the, like, the particular Medicaid program integrity activities that they say that they will streamline are the ones where the states have sort of been loudly saying, these are burdensome and these have no value, and where even the GAO has come in and said there's no return on investment. So, CMS has dialed those back and is taking those out.

But, our recommendation was that they should look across the federal program integrity approach, look for those activities that are outdated, have little return on investment, are ineffective, and find a way to address those, and this plan does not address how they're going to do that for anything that hadn't already been called out by somebody else, like the GAO. So, the things that are already on the table, they say they're dealing with, but there's not really any plan to sort of systematically look at the rest of what they're doing.

Similarly, we said just this past March in our chapter on supplemental payments that they should collect and make publicly available the UPL supplemental provider payment data, you know, at the provider level in a way that's accessible and can be used for analysis and be used for oversight, and so while

they have an activity around that, they don't say anything about making the data available to anyone other than their own staff.

So, they touched on a lot of recommendations that external groups have made, but they haven't really followed them all the way through, not that they have to, but they had opportunities to do so and declined.

I would say that the bigger concern I had with the plan when I read it is that it's comprehensive in scope. It's much, much better than the last plan in terms of addressing a range of activities and organizations that are involved in the administration of the Medicaid program, you know, managed care, eligibility of state claim, and all of these things. But, there is -- the lack of detail about how they're actually going to do any of these things really raises a lot of questions about how CMS is going to ensure that it gets done and how anyone is going to hold them accountable.

For example, the introduction to the plan acknowledges that all these parts of CMS beyond the Center for Program Integrity are going to share in program integrity responsibilities -- the Center for Medicaid and CHIP Services, the Duals Office, and so on -- but, in the list of actual activities, it never references who is responsible for almost all of them. If it's not the CPI, then it doesn't say who is going to be responsible for doing them. Duplication of effort has been a persistent complaint about the federal approach to Medicaid program integrity, so it would be helpful to know who is responsible, how they're making sure they're communicating, what the feedback loops are, and so on, and that is just sort of absent from this plan.

In addition, a lot of the activities described in the plan, especially the ones that aren't explicitly required by statute that was detailed about what was required, don't include a lot of information about who will be responsible, when things will be done. Even for things that are underway already, there are no milestones. There are no time frames. So, while I think it's a big positive that this plan

incorporates such a broader range of things across the federal Medicaid enterprise, the lack of detail makes it really difficult, again, for oversight and for planning. I mean, providers and states and other stakeholders need to understand when they can expect things to happen, and the lack of detail, I think, will make it really difficult both to execute on and to provide oversight.

So, we had -- in the memo, we had identified three specific things that we thought would be helpful in terms of strengthening the federal Medicaid program integrity strategy, so I was hoping that the Commission could weigh in on those priorities and see if there are other things you think we should suggest to CMS.

The three things were, one, provide more clarity around responsibilities and coordination among CMS offices. The plan should address the accountable offices for each activity, describe the feedback loops structured among the various offices, and indicate how progress will be monitored, like, who is accountable.

Two, provide specific time frames for initiating activities not currently underway and more information on milestones and time frames for those activities that they are doing now so that policies can hold CMS accountable and so that other stakeholders can plan appropriately.

And three, adhere to the timelines for completing the migration of data to the T-MSIS standards, so that they can actually start using the data to execute on all the activities that rely on that data.

So these aren't issues -- this list isn't -- these are things we would go back to CMS with. These aren't really things where staff can weigh in a lot more.

But my other question, beyond, sort of, is this the right list, is do you want to give feedback to CMS or to the Congress, or is there other follow-up action that you would like staff to take?

CHAIR ROWLAND: Thank you.

I will start with David and then Judith.

VICE CHAIR SUNDWALL: Thank you, Moira.

Since we have met, this has been an issue of importance. It's gone over the years, but I'd like to know if you have a degree -- or maybe Anne does -- a sense of a temperature of the Congress now on these issues. Has this faded into the lower list of priorities, or is this still something of great interest on the Hill?

EXECUTIVE DIRECTOR SCHWARTZ: Well, that's a great question. I know there is definitely interest on the Senate side. We have been hearing peeps and whispers about program integrity, a bill coming out sometime this year. It still hasn't seen something yet, but there is definitely still interest.

VICE CHAIR SUNDWALL: Just one more quick comment. As someone who used to be responsible for the Medicaid program in Utah, it became the topic of the day in the legislature the last couple of years I was there, and it was brutal, their review, and it was like a sledgehammer. It was not targeted. It was not helpful, in my opinion, but in their need to do something, they pulled program integrity out of the health department and created a new Office of Program Integrity in the Attorney General's office, I think using the Texas model, which I don't know how many other states have adopted, but it gave a higher profile and an indication that they cared deeply about fraud and abuse and were going to do something, which seemed to me like rearranging the deck chairs more than much constructive change. But it is an important issue, for sure.

COMMISSIONER ROSENBAUM: I always find when we get into this issue that it is here and it's not us. It is the issue, and it's CMS as grappling with the issue.

That what always happens in these things is that everybody sort of loses sight of what are the fundamentals, what are the way things, given the way Medicaid functions, that ought to, in plain English, be of greatest concern. And what's very hard from there -- I agree with your assessment completely. Not only is it very hard to understand how they are going to manage the project, manage program integrity --

and I think some of that may be just a pure staffing problem. That's another issue that we should talk about. But what is lost in all of this is a very fundamental, plain spoken way of explaining to Congress, to itself, to the public what are the areas that we think are the most subject, potentially subject to problems.

One of the areas that I think is incredibly potentially subject to problems, although the irony is I'm not sure how this cuts inside the administration, is what happens when Medicaid is incorrectly paying for people who are eligible for totally federally financed premium subsidies and are mistakenly showing up on the Medicaid side of the ledger?

I mean, in effect, it's saving the federal Medicaid account -- it's saving the federal accounts a bunch of money. Is that considered an error? I mean, it should be considered an error if states are being incorrectly charged for the cost of subsidizing health care that ought to be subsidized out of the tax benefits.

And does the plan reflect this at all? I realize that here, we may be working against everybody's federal interest, but I think it's important for us to flag that in the modern system, as we now know it, this is an area that I would say is high risk to Medicaid when Medicaid would get unfairly tarred with erroneous payments, when in fact what may be going on is also a problem with the working of the premium subsidy side of the ledger.

So I don't know whether we flagged it enough, whether we want to try and get more clarity from CMS.

CHAIR ROWLAND: Just to follow up for a minute on Sara's point, what are their plans for fraud and abuse and program integrity in premium assistance plans that are private plans that federal money is going substantially into? I think that is an issue that we ought to look at and comment on.

Judith.

COMMISSIONER MOORE: I think it would be very useful if their plan were easier for Congress and anyone interested -- and certainly MACPAC -- to oversee and with the clear time frames and

indication of who was going to do what. And I don't have any objection to suggesting that those are good ideas.

I would like not for us to get too much into that kind of process stuff, but rather for us to be thinking about priorities that we would want to see them emphasize, and certainly, the premium assistance is one.

And for my own self, the work around availability to the states of Medicare data would be certainly high on the list and one of those nice things to do to integrate to programs for the 50th anniversary next year.

Also, Sara and I were part of an exercise many, many years ago in the '90s to work with states around Medicaid managed care and fraud and abuse activities in that vein, and I suspect there is still a lot of work to be done there. But particularly, again, harkening back to priorities, managed long-term supports and services, which is a relatively new phenomenon and I'm sure there have got to be some good ideas for looking at how to monitor, how to look for fraud and abuse and waste in those programs, so that would be high on my priority list.

It is just sort of common sense that with additional data and better data systems, the predictive modeling stuff should be high on a priority list and the supplemental payments issues.

So in terms of priorities that I would want to put on the list, those would be mine.

And I guess I have an old federal administrator perspective in terms of saying let's let them decide who is going to do what and not be too prescriptive in terms of our oversight in that kind of area.

CHAIR ROWLAND: Patty and then Trish.

COMMISSIONER GABOW: Thanks. My favorite subject.

So I wonder how much was pushed or how much we should push, that you have a lot less issue around fraud and abuse if you simplify the program, and the more rules you have, the more complex

the program is, the more you have to dump money into detecting errors, I would like to say, as opposed to fraud and abuse. And I think we should continue to sing that song, that if you would simplify the program, you would need less effort in this.

Another theme that has come out of this Commission that I think we should emphasize is that if you provide more up-front dollars for administering the program the way a private company would administer something of this magnitude, the less you are going to have to invest in fraud and abuse. You can either do it on the back end or at the front end, and I think we have been trying to say that in other components of our report. And this is a place to emphasize it.

I would also like to talk about the predictive analytics and the prioritization that Judy and Sara brought up. Given if their data systems become more timely and more robust, then using predictive analytics to say where is the bang for the buck and assuming that the 80/20 rule applies to errors and fraud and abuse, just like it does to everything else in life, one could use predictive analytics to say, "Well, then here are the 20 percent of the issues that generate 80 percent, not of the errors, but of the dollars.

I mean, you could have errors that are a penny apiece and have thousands of them, but who cares? You really want to use your predictive analysis to say here are the 20 percent of things that really cause us to have 80 percent of the inappropriate expenditures, and I think we should encourage the use of that, rather than four auditors coming in for one month to go through claims to find your two penny errors.

The other thing about your first bullet, I think we really have to continue to sing this song at duplication across different components of the federal government and state government is really wasteful. And it's not just that they integrate to catalog, but they get rid of all the duplication. Nobody should be doing this -- we shouldn't have any two entities doing the same thing.

And the last thing I would say is the feedback loop issue is not just that we talked about when some of them came here. It's not just the feedback loop between the federal entities, but a feedback

loop between the rule and the provider. I mean, if you find either in their predictive analytics or in their other methodologies that there are certain rules that are always being a problem, if this were a patient problem, we wouldn't -- I mean, if we always had patients getting a central line infection, we wouldn't say, "Gee, the providers are setting out to create central line infections in as many people as possible, so that they can bill at a higher level." We'd say, "Gee, there is something wrong with our system that is causing all these central line problems, so let's go back."

And that feedback loop between the regulatory entities and the providers seems to be completely lacking or at least non-robust.

So I think those are the things that I think we should -- I think those set of things, I think we should continue to push as we look at this area.

COMMISSIONER RILEY: When I think about CMS and the incredible load upon them as they implement the Affordable Care Act, I would be inclined not to ask them to do any more. It might be nice to see some benchmarks and some clearer, you know, when we'll see stuff.

But it seems to me there's a good deal of work here that's important, that the priorities that Judy listed are already here on their plate, and we should applaud them for doing that and not ask them to do more at this point, because I just think that they have taken a big chunk of what we want, maybe not at the level that we wanted.

The only thing I might add on the data analytics is to try to move us to a recognition that Medicaid does not live alone anymore. It lives in a marketplace.

So when you think about technical assistance for data analysis at the state Medicaid agencies, I would encourage them to engage all payer data claims databases where possible and to do the data analytics with those, as well, because it seems to me state Medicaid agencies need a lot of help to work with those entities and to figure out how to do the analytics in an all-payer environment.

COMMISSIONER HOYT: Moira, I think you mentioned ROI somewhere in there when you were going through the slides. So does CMS keep score? You mentioned benchmarks. Do they track state by state what the ROI is and use that to build best practices?

MS. FORBES: They had ROI on a specific federal audit program where they had paid contractors several hundred million dollars and they had only recovered a few million dollars. So that was a clear lack of ROI, and so CMS is changing its contracting strategy. But they don't, I think, generally have a good way to measure the effectiveness of federal or state activities.

There's no uniform way to measure it at the state level, and there's not, I would say, a good way to measure the return on the federal activities.

COMMISSIONER HOYT: A follow-up. Isn't that the way the vendors sell this a lot of times? I know there's accounting firms that do this.

MS. FORBES: And that's what's not uniform.

COMMISSIONER HOYT: Why not keep score state by state? Is it just not doable?

MS. FORBES: I think some activities lend themselves to clear measurement, and some don't. And there's also cost avoidance versus cost recoveries, and how all that gets measured, I think is where there isn't a lot of good direction to help folks understand, and since we rely on the vendors for a lot of it themselves. I think those are some of the concerns that have been raised at least in the community, among the states, about the problems with measuring ROI.

CHAIR ROWLAND: So if the Commission were to comment on this report, what comments would you want to make or not make any at all is the decision we have to weigh here.

I also think that one of the points we always try to make is there's importance to making sure the Medicaid program itself is well staffed and well managed, and that we really, in my mind, need to also revisit what it takes to run an effective Medicaid program.

We've had several individuals, new budget directors in some states asking how do you do Medicaid projections, is there a method for how those should be done. So I think there is a lot of interest in kind of how we improve the front end of Medicaid as well as the look-back part.

But what is the Commission's sense on what to do with regard to this particular report? Trish?

COMMISSIONER RILEY: I really feel like it's a step in the right direction, given everything else on their plate. We should applaud that, but frame it around these -- that it doesn't go as far as we'd like, but that these are important steps. We'd like a report back on how well they've met these goals, and then we can measure it against it. But frame it around Patty's notion of simplicity. Wherever you can eliminate redundancy and duplication, we should because that helps with fraud and abuse, and frame it around the front end. Investment in the management of the program is a better way to reduce fraud and abuse than to wait until the back end.

CHAIR ROWLAND: Any other comments? Andy.

COMMISSIONER COHEN: I would just add to that list of Trish's, the importance of doing -- I almost laugh when I see the term "a comprehensive Medicaid integrity plan," because really, to be comprehensive or unified, it just has to be -- it has to include the now-four or five federal programs that relate to the same health care delivery system, more or less, and sort of to do the alignment integration between programs as much as possible.

CHAIR ROWLAND: And I would really like to see raised the issue of much of the fraud and abuse activities based on the traditional way Medicaid has operated, and if we're operating under premium assistance and other kinds of interactions where basically the federal government is making payments to private insurance plans, where is the measuring going on there? And I don't think that was at all addressed in this plan, as I could see it.

So, really, we're saying there's a whole new world of how Medicaid is interacting with other payers and other providers, and a Medicaid-only plan is not really speaking to the most prudent use of federal dollars and monitoring of federal dollars.

Denise?

COMMISSIONER HENNING: And let's not forget there's also the monkey wrench that's going to get thrown into the system, come October 2015, when ICD10 becomes mandatory and all of the providers out there in the U.S. are going to have to figure out how to code correctly. And we're probably, a lot of us, going to be coding incorrectly, not on purpose, but because we're just not familiar with the new codes. And that's just going to be a learning curve, and how does that play into your encounter-level data and that kind of thing?

Actually, Steve can probably address that better than I can. I'm looking forward to it, not exactly.

CHAIR ROWLAND: Okay. Thank you, Moira.

And with that, we will ask if there is anybody that would like to make a comment from the public or offer a suggestion to us.

PUBLIC COMMENT

[No response.]

CHAIR ROWLAND: And hearing silence or seeing silence, I will then call this meeting to adjournment and ask, though, that the Commission members stay for a brief discussion about tomorrow's agenda.

[Whereupon, at 4:10 p.m., the meeting was recessed, to reconvene on Friday, September 19, 2014.]

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, September 19, 2014
10:47 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
JUDITH MOORE
TRISH RILEY, MS
SARA ROSENBAUM, JD
STEVEN WALDREN, MD, MS

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S [10:47 a.m.]

CHAIR ROWLAND: Okay, if we can get started? I think we are missing a few Commission members, so we'll pause a minute.

Let the record reflect that Herman is here ready to go. Judy is next.

We're going to resume this meeting of MACPAC to open with a very important look at some of the early experiences of new Medicaid enrollees, insights from six focus groups. This follows up on some earlier work of the Commission to look at the potential experiences of individuals who would be eligible, so now we have some on-the-ground experience. I'm going to turn to Veronica to set up the discussion and welcome Michael Perry from PerryUndem to present the results.

SESSION 5:

EARLY EXPERIENCES OF NEW MEDICAID ENROLLEES: INSIGHTS FROM SIX FOCUS GROUPS

* MS. DAHER: Thank you. Yes, so we're really happy to have Mike Perry with us today. He is a partner at PerryUndem Research and Communication. You may remember that in January he was before the Commission to talk about phase one of the focus groups where we were speaking with new enrollees as well as potential new enrollees about their experiences enrolling in the Medicaid expansion.

So we've done phase two now this summer where we spoke to newly eligible enrollees about their experiences using their new Medicaid coverage. And so our goal today is to spur discussion about how these results can inform future Commission work. So thank you, Mike.

* MR. PERRY: Thank you. Thank you, MACPAC, for letting me work on this great project.

So what I'm going to talk about is the findings from these six focus groups. The reason we did focus groups is we really wanted the personal stories, the human face of what is going on with new Medicaid enrollees. In this conversation, we did a lookback and did ask about why they enrolled, what the enrollment process was like. We spent some time there. But then we focused on utilization, what their experiences had been so far, and then we looked a little bit in the future as well about renewing and their intention to renew.

So those are the topics we discussed. We held this research in June and July. We went to Chicago, Denver, Portland, Oregon. So we went to states that expanded Medicaid. A lot of these were newly eligible individuals because of the expansion, first-time Medicaid enrollees, so it was interesting hearing their experiences.

We also wanted to hear from some important subgroups, so we held two groups with Latinos, one in Spanish. We did two groups with young adults 18 to 34. We did one group with parents, and we did one group with childless adults. So we wanted to hear different perspectives.

So let us start off. Life before the Affordable Care Act. We wanted to ask them what their experiences were with health care before enrolling in Medicaid. What we found -- I do a lot of work with the uninsured. These individuals sound a lot like other uninsured in that they were putting off care. They were not getting any preventive care at all. They were doing a lot of home remedies, trying to not interact with the health care system because they just couldn't afford it. So we had people who hadn't received any preventive care for many years. We had a lot of individuals who did not have a primary care physician, didn't have that relationship at all.

These individuals did look for health -- most of them did look for health insurance before.

A lot of them looked at Medicaid before, but because of their family status, because of their income, could not qualify for Medicaid, thought, you know, that was it, I can't qualify for Medicaid, were surprised to find they could now be eligible.

We also had individuals who had been insured fairly recently and lost their coverage and were just looking for coverage.

I think the thing that I noted here is that these individuals were motivated, and, again, I've done a lot of research with the individuals who enrolled during this first open enrollment period, and they do seem to be motivated kinds of individuals. The people in our focus groups, they really did not like being uninsured. A lot of them had chronic health conditions. They had been looking for health insurance. They really got it -- they put up with some challenges in the enrollment process because they were so motivated to get insurance. So this was a motivated group of individuals in our study.

So why did they enroll? They had a sense that there could be affordable health care coverage. They saw -- the news coverage was their main source of information on this. They knew the Affordable Care Act was available.

What they didn't know was that Medicaid has expanded. I keep on finding that in my research, and I said that last time I was here, that that message isn't out there. So these individuals went to enroll not knowing they could qualify for Medicaid. It was a surprise for a lot of them in the process that they could qualify.

What drove them to enroll was the fine, the law, wanting to be in compliance, to get affordable health coverage, to manage chronic health conditions. We had a number of individuals who, because of pre-existing conditions, just could not get insurance until this opportunity, and for their families.

So this was particularly true of the younger individuals, and I think of some young people in Portland, you know, it was mom. "Mom made me sign up for health insurance." So we can't underestimate the power of moms and family in getting people to enroll.

So what are their feelings about Medicaid? Now that they're inside of Medicaid, most are very happy that this option was available to them. Like I said, they did not like being uninsured. They were pretty glad they could now have affordable health insurance. They feel better off now than they were before.

We talked about what the feeling was. What was that feeling? What is that feeling now that you have about having coverage, about being in Medicaid? It was about having one less worry, feelings of relief. I think it's important to understand the context of these individuals' lives, and for them, getting coverage was a sign of stability, of moving forward, a step forward. They don't want to go back.

So Medicaid has a psychological, almost emotional impact as well as the very clear health benefits. But it really meant a lot to be able to get coverage to these individuals. They don't want to go back.

Many said their health has improved since enrolling in Medicaid, so that was a really interesting finding. We had a number of people who had a new diagnosis since they were in -- since they got in Medicaid, they went to see the doctor. High blood pressure was mentioned a couple times. Recently diagnosed, now on medication. It's because they got Medicaid.

We had a guy in Portland who was biking, was in an accident. In the past he wouldn't have gone for any urgent care at all. He just would have nursed his wounds at home. Now he could go and get the care and the follow-up that he needed because he had Medicaid.

And then we had individuals with chronic conditions, diabetes -- depression came up a lot, untreated depression, and how with Medicaid they were able to treat depression. So we heard stories of health improving because they received Medicaid.

There are some stigma issues, though, particularly for first-time enrollees. Some of it is perceived, and some of it they say they have experienced. So the perceptual is that they just believe they're going to get lower-quality care when they interact with the system. It hasn't happened, but they believe that's probably the case. They believe that they're not going to be offered certain treatments because Medicaid is for low-income people, there have to be limits. They believe that there are going to be some limits on what they can access.

And then there are some individuals who think that they've actually experienced stigma with Medicaid when they call, you know, on their fifth provider and trying to get into a provider and the provider is saying they're not going to see Medicaid, even those they're on the approved provider list. They're saying, you know, we're full, we can't see you. They think it's because it's Medicaid, they don't want Medicaid. So there is some perceptual. Some are believing they're experiencing stigma in the program.

Experience with enrollment and choosing a plan. You know, it went pretty smoothly for these Medicaid enrollees. I was really surprised to hear that. I think it has to be in context, though. They did experience some problems enrolling, so there were some website glitches. There were lost applications. So about four or five had to reapply because the application was lost. Long waits when they called the customer service line, phone number. And some were stuck in the process quite a while, unclear where their application was. But they tended to view these as just hassles that go along with enrolling and didn't really seem to see any of these as major problems. They just were expected and things

that they overcame. So they gave pretty high marks for the enrollment process.

When we asked them about choice of plans, it seems that in Chicago and Portland, those two sites, there was a choice of plans, and some people did a lot of research, just like other consumers I've been talking to. They tracked down where their provider was going to participate, and they saw what urgent care centers and hospitals were in the plan. They wanted one that was convenient. They did some research. Others did not. Others just went with a name that they thought they recognized and chose a plan that way.

They didn't seem to think that choosing a plan was that difficult, and I thought that I'd hear more attention around auto-enrollment. We had a number of individuals in Portland who were auto-enrolled in a plan, but in a way they thought it was a relief that that choice was made for them. And there wasn't a lot of complaints around auto-enrollment.

So knowledge about how Medicaid works. I think this is a finding that's important. We found a real big knowledge gap around how Medicaid works. Part of me thinks it has to do with the fact that they weren't prepared to enroll in Medicaid from the start. They just went into the enrollment process, boom, I'm in Medicaid, and then now they're supposed to be using their health coverage. So there is this problem now with the newly enrolled that they don't really understand their coverage. They don't understand what limits they're going to encounter.

Some of the kinds of things that they're questioning is, for example, dental care, as you know, is an important service. A lot of the people who signed up and got Medicaid thought they would get access to more dental care than they're finding they are getting access to. They're not sure what dental services they can access, so that came up, a lot of confusion, what providers are covered, what services are

covered.

They don't know what limits they may face on their services. A number of individuals in Portland seeking mental health services are having challenges accessing a psychiatrist, for example, are seeing other levels of providers. They don't know -- they didn't know that was a limit in Medicaid or if that's because of Medicaid or their managed care plans. Some of this is around their managed care plans. Some of it is around Medicaid. They're confused about which is which.

They have some questions about their share of costs. They don't know that if they really need their Medicaid and have to go to the hospital and have surgery done and have a really large cost, are they going to have to pay a big share of that? They don't know about that. So those are some of the questions that came up.

In terms of what information they're getting, a few of them -- not a lot -- did receive a booklet in the mail when they enrolled. It's unclear if it came from -- and they didn't know if it came from Medicaid or from the managed care plan that they enrolled in. But they got -- mostly what was in there was a list of providers. But most of them said they received nothing, they received no print materials about their coverage and what to do.

Some said they were directed to go to a website. I heard that in Denver. They're supposed to go to a website to read more about their coverage. Some did, some didn't. But there's nothing in hand that explains how their Medicaid works, and there's no one who -- I think the insight was enrolling was not an educating experience around Medicaid. It was just to get to the other side, and then now there really isn't something there.

They're relying sometimes on those groups that helped them with coverage before they had

insurance, going back to them and asking questions, but there's a big information gap going out there.

I think with the individuals who had Medicaid sometime in the past and now got it again, I think there's an update needed. They have some old perceptions of Medicaid. They're not up to date about what it covers, limits, how to enroll, that it expanded. So they think they know, but they have some gaps in knowledge.

And then they don't know about the renewal process. I'll talk about that in a minute. But they don't know about the renewal process. Those with SNAP, you know, they chimed in right away and said, okay, yes, I know I'm supposed to renew every six months for my Medicaid just like my SNAP, which is, you know, inaccurate. And then the new first-time enrollees don't know about renewal. So this was in July, so I don't know when that conversation needs to start, but they're not hearing about renewing.

So experience using services, what has utilization been like? It has been mixed. It has varied by site. Generally, if I had to give you a feeling, the Denver participants are really happy. Everything seems to be going well. They're getting providers. Not an issue. Chicago participants, not so happy, difficulty getting into providers. They're not finding providers, specialists or primary care, who will take and see them. So they're hearing problems there.

In Portland, Oregon, it was mixed. We had one group, everything seemed to be clicking, working really well, and one group where they were running into problems around access to care again. So obviously this is geographic differences here and size of networks and all that come into play. But we heard some mixed experience.

So, number one, I think the main issue where frustration is is around finding a primary care provider. And it's not just that there aren't enough, and that isn't a problem everywhere. But in some of

the sites, they feel there aren't enough primary care providers. But it's not -- they don't know how to do this. A lot of them have not had a primary care provider for a long, long time. They're not sure how you go about doing it.

Some admitted in the focus groups they've been putting it off because it just seems like a daunting task. They don't even know where to begin. So we have to remember, a lot of these individuals, this is the first time with insurance, they don't know how to go about finding primary care.

Finding a specialist has been difficult for a few people.

Filling prescriptions, we heard that a lot. The issue there -- there's a couple issues. One is just a traditional issue we've heard before in any kind of insurance. My provider prescribed something else. I went to the pharmacy, and they don't cover that medication. And so for a first-time enrollee, they're not sure how to deal with this issue. And so they go back to their provider, and they feel like they're caught in between trying to resolve these issues.

Then we had some people who went to the pharmacy and their status -- even though they had the Medicaid card, their status seems to be still unclear. Maybe there hasn't been a paid premium or something, they haven't -- not a paid premium, but they haven't submitted documentation that they were supposed to submit still. And because of those eligibility status issue, even though they had the Medicaid card, they have to keep going back to Medicaid clarifying it and then they can get their prescriptions. So things are going on with prescriptions.

And then accessing mental health providers again came up in Portland and wanting to see a psychiatrist but instead being directed to other levels of providers that they were not necessarily happy with.

I think the thing to keep in mind, as I do a lot of research on health coverage -- and they're

never happy conversations. People don't go around raving about their health insurance. They talk about these kinds of problems in any kind of insurance. I just want to put that context out there. It's just these problems come up in a lot of the work we do, are not necessarily unique to Medicaid, but they came up in these groups.

So, looking forward, where are they headed? We really found that these individuals seemed motivated to keep their Medicaid. So when I brought up the renewal conversation, it made a lot of them nervous that they hadn't heard about this and could I lose my Medicaid and what do I need to do to keep it. So by not talking about renewing, there could be a lot of anxiety out there when they first get that first letter, you know, "it's time to renew" notice. So I think we need to pave the way a little bit around renewals, that this is a responsibility and this is the way for them to keep their coverage, remind them why coverage is really important. But they seem motivated to stay enrolled.

They don't want to be uninsured again. I mean, that's the main reminder of what it was like to be uninsured, and the debt -- a lot of them have a lot of medical debt -- is the reason they want to keep their Medicaid, primary reason.

A lot of them have been spreading the word around Medicaid. Again, it was news to them that Medicaid -- something about Medicaid had changed and that they could now be eligible, so they're trying to spread the word among friends and family.

And then, you know, they need to find out about the renewal process.

So those are the big takeaways from the research. I'd love to hear your questions and thoughts about all this.

CHAIR ROWLAND: Great. Thank you very much. I think this is very instructive to

help us know where we need to go further, and as we look at this, I'd ask the Commission members to think about what the next step is in digging deeper on some of these early findings. David had a quick comment.

VICE CHAIR SUNDWALL: I just want to compliment you. That was really interesting to me, and I have a personal story to tell you about renewal and how important that is.

When I was head of the Health Department in Utah -- this happened on a Sunday -- the press came out with there was a man at the airport waiting to kill the governor who was coming back from a trip to Iraq with the National Guard. He was a Medicaid beneficiary who had not renewed, and his family -- I somehow managed to get in touch with them, and they were in a panic because they didn't have the $200-some to get his psychotropic drug without the Medicaid card. So I managed to go the Walgreens in their neighborhood and pay for their drug, got him on his meds. And on his meds he was okay. But he was really totally deranged without his medication, but it made a big press thing. It did take me about three months to get my reimbursement from Medicaid, but it was worth it.

CHAIR ROWLAND: Okay. Comments? Questions?

COMMISSIONER MOORE: You mentioned that most of the folks you talked to were very motivated to sign up, and I wondered if you thought that was universal or if you thought it had something to do with the specific groups that you chose or the states and areas that you were in, because I hadn't actually thought about it before, but I would have had the impression that there wasn't universal motivation but it was really more related to people who needed and were more sophisticated about things. So I'd be curious to know about that.

MR. PERRY: It's a good question. I will tell you, in work I am doing right now looking

at the remaining uninsured and looking into the next open enrollment period, I am noticing a difference in motivation level. So I think that the round one generally I would say were more motivated consumers to get insurance. But when you break that down, you are right, the people in our studies, we had a number with chronic conditions, they tend to be a really motivated group in our research. They really have been putting off care, particularly the individuals dealing with depression. You know, it's hard to function without getting the care you need, and so they are really motivated, really willing to put -- go through multiple steps to get through.

And, you know, that's why I thought it was so interesting that the enrollment process -- that conversation was really positive. Even though they were telling me, "Well, my application was lost, and then I had to call, but then it was straightened out." They were so glad to be on the other side of it that they -- so they were really motivated.

I think we purposely looked at this younger and healthier group that's in Medicaid in this study as well, and they were a little less motivated, but it tended to be the mom who was the motivator or someone around them really pushing them towards coverage. So they were slightly less motivated, but they had motivation around them to enroll.

COMMISSIONER GABOW: Did you have data on plans they enrolled in? I am particularly interested, since in Denver, I know that their numbers -- I don't know here -- new enrollees went to Denver Health, in the Denver Health Plan. And, I would guess, but I can't, of course, prove this, that if they went to a safety net plan that included FQHCs, that it was much less difficulty in getting access to primary care.

I would also surmise that some of these patients with primary chronic -- with chronic

disease, if they enrolled with a safety net plan, were previously getting their care in that safety net and now might have even more access. Do you have any information about that?

MR. PERRY: Not specific, and Veronica, I don't know if you have thoughts on this, the different plans that we looked at. But, I mean, it's interesting you pointed to Denver, because Denver was where we had the happiest, most satisfied, less access problems. And, I think you're exactly right. That's because of where they were going and the plans they were in. I don't know the plans that they were in in Chicago. I think we got an array of plans, and, then, in Portland, as well. But, I think it's a good thing to look at.

MS. DAHER: Well, I just wanted to say, we did not survey them on the names of the plans that they enrolled in, but I definitely remember that in Denver, they specifically mentioned Denver Health as a resource that they went to to help them understand Medicaid. Whether or not they had enrolled in the Denver Health plan, they went back to that location for assistance.

CHAIR ROWLAND: Did you find out at all where they had gone previously while they were uninsured or not? Did you just start with the Medicaid enrollment process?

MR. PERRY: Were they going for care?

CHAIR ROWLAND: Beforehand.

MR. PERRY: Yeah. Some were, yes. So, Denver Health, the individuals were -- we --

CHAIR ROWLAND: So, had been using Denver Health.

MR. PERRY: Yes, exactly. Had been using Denver Health. Exactly.

CHAIR ROWLAND: Okay. Burt, and then Denise and then Herman.

COMMISSIONER EDELSTEIN: It's terrific to hear that they were impressed with the

comprehensiveness of the benefit that they received, and you mentioned that dental came to the top. And in this particular case, they were correct. There's no one in this room who doesn't know that the program profoundly fails adults on dental care. So, in this particular case, when they were concerned that they weren't able to access something, it's because, in fact, by and large, they can't.

But, did you get a sense of what that meant to them as people? Is it an aesthetic concern? Is it an employability concern? What did it mean to them, that they wanted and couldn't access dental?

MR. PERRY: That's a great question. So, in this work, not only these focus groups but other focus groups I've done with Medicaid enrollees, dental care comes up always as a top, top health service that they're really interested in. It's just really, really important.

It was -- in this case, I think a number of these individuals thought -- I mean, dental care, getting dental care was a driver for them to sign up. So, they really thought they were going to access it. So, it was a disappointment on the other side that they weren't. So, it's that important. It's so important that some people will name that as one of the things that they were most looking forward to in getting Medicaid and then don't get it on the other side. So, big disappointment, more than any other health service, the frustration and disappointment around dental care.

It's way more than aesthetic. It's just the cost. If they have any kind of dental issue, the cost out of pocket is too much, is just too much. I mean, we had people talk about some other bills that they've had to pay out of pocket. It's just too much for them.

And, a lot of them are dealing with pain, so it's a pain issue, too. Because they can't get the dental care, they can't afford it, they are dealing with pain. We had some people in the focus group dealing with some dental pain. So, it's pain relief. It's way more than just aesthetic.

And, I think it does speak to employability, too. We've heard that in some of our other work, that it's easier to get a job with a great smile, and when you can't -- and when you just had an extraction, which is what Medicaid will pay for, it's a hard thing.

COMMISSIONER HENNING: I work for an FQHC in Florida, and a couple of different questions that have to do -- channeling Patty, more than one question here.

One thing that we find in Florida, which I find very curious, is that we can have psychologists -- in fact, we do at our health center -- that see patients, yet they are not allowed by state statute to prescribe psychotropic medications. So, the psychologist will see the patient. He will walk over to me and say, "This patient needs a prescription for an antidepressant," and I, as a nurse practitioner, will write the prescription without really actually seeing the patient sometimes, although I usually am the one that sent her to him in the first place. But, still, it's kind of weird that Medicaid in my state doesn't pay -- or, doesn't allow them to write the prescription.

And, on the other side, they also don't allow the psychologist to bill. So, he can see them, but he can't bill for the visit. So, we find that a little curious. And, the only way we can provide the service for our patients is the fact that we have an association with Florida State College of Medicine, who provides us with the psychology personnel to staff our department. There's something wrong with this whole picture.

MR. PERRY: Yeah.

COMMISSIONER HENNING: You know, we need to bring mental health into this century to the point where it's considered to be part of health care in the way that dental needs to be brought in.

[Off microphone comments.]

COMMISSIONER HENNING: Well, better, you know.

And, then, the other issue is I love this study. I think it's great, and I'm going to suggest your next one, and that is why don't we look at the people in the non-expansion states that fall into that 100 percent to 133 percent, where they can't buy a qualified health plan and they can't qualify for Medicaid. These people are still uninsured and they don't really look any different from either one of those populations, and they're the ones that pretty much -- they fell through the crack. They're being left out. And, they go to try to sign up for some of this stuff and get told that, sorry, you don't qualify, but, I wonder, does anybody really explain to them that you don't qualify because your legislature decided that they didn't want to expand Medicaid, and until you change your legislature, that's not going to happen?

COMMISSIONER GRAY: We've talked here before about the cultural issues from the provider perspective, that even with comparable payment rates, as an example, some offices don't want Medicaid patients in their office. And, you mentioned in this study the perception that there was a stigma attached to Medicaid, but the examples you gave are primarily related to finding a provider. Any stories at all or examples of people who had sort of real world -- you know, once they got past that hurdle of actually receiving service, that they felt they were stigmatized in some way, or felt that there were cultural issues, or they felt less than equal, or any sense of that at all?

MR. PERRY: So, great question. So, beyond those kind of finding a provider kind of issues, I think very little sense that -- of stigma once they access care and get the care. We did find an individual -- one or two individuals running up against some limits, and they attached that to Medicaid.

So, we had an individual, for example, with a cyst on his lower back that was causing a lot of

pain, but it was deemed that it was not a health threat and, therefore, he is not able to have it removed. So, he thought that that had -- that's what he was told by his provider. So, he has to live with this, although laying down and sleeping is very difficult because of this cyst on his lower back. So, he thought that had something to do with, okay, I'm a Medicaid patient. I don't deserve to be able to have this removed because I'm on Medicaid. So, again, I don't know if that's a plan limitation or a Medicaid limitation that he was coming up against. He would blame it on Medicaid when he was talking, but -- so, we had that. We had his experience.

COMMISSIONER COHEN: Umm, I have two questions. You'll cut me off, Diane, if you must.

The first is, did any -- did you explore with them -- I didn't see it, but did you explore with them or did it come up at all with the participants that they had any experience with, like, navigators in any form or another, either through a provider or a health home or from an outreach, someone who actually got them on coverage? Like, did that come up at all?

MR. PERRY: It did. So, we purposely tried to find individuals who signed up a lot of different ways. So, we had a group that came in through Medicaid because of a navigator, because of a personal contact where someone helped them through the process, and they were very happy with that. That was a key process. Latinos, in particular, really benefitted from the walking through the process. So, they were valued --

COMMISSIONER COHEN: Were they --

MR. PERRY: -- they seemed happy.

COMMISSIONER COHEN: I'm so sorry. And, they were just people who helped them

get signed up and straighten out their coverage, or maybe also find -- were they multi-purpose navigators or just navigators for --

MR. PERRY: Great questions, and I'm not sure. The role of navigator is not really well understood. So, and sometimes, it was clear to me they were talking about someone at the health clinic they've been going to, FQHC, for example, and I'm not sure if that person had the designation as a CAC or enrollment assister, but that was the person who helped them enroll. So, there was someone at an emergency room who helped them to enroll.

So, that's as far as I could get. I couldn't ask questions, or they couldn't explain that that person was trained to do this and actually could do the whole process from beginning to end. So, I think there was a mix of navigators and then also just people who have always supported them who were helping them through the process.

CHAIR ROWLAND: I think some of what we've heard is that the navigators help people sign up, but then there's no one there to help them figure out how to use what they've signed up for.

MR. PERRY: Exactly. Exactly.

COMMISSIONER COHEN: Nobody was helping them, or, again, in your conversations, they didn't have people who are kind of helping them, once they were enrolled, manage the prescription coverage issue or the formulary issue or something like that.

MR. PERRY: There was confusion around that. So, I went back to Denver Health. Denver Health came up. So, the providers who they were going to when they were uninsured, some of them on their own are going back, not that they were invited to or told to come back, but they're going back to get help from them.

But, there's no one -- I think the confusion we found was that there was no direction for them. They didn't know who to call after they got through the enrollment process to help them with these things. So, they called the providers sometimes. They went back to Denver Health. They went -- they just found them on their own. They would love to have been there -- okay, now you're enrolled. Here is who you call. Here is the phone number you call when you have this kind of issue. They didn't get that.

VICE CHAIR SUNDWALL: I'm just going to say, with our managed care plans -- in Utah, there are four now -- they have a case manager. I mean, I see these patients in clinic. I'm kind of surprised to hear that, because it's in their interest with these capitated payments to make sure people are using care appropriately and they're assigned a primary care doctor. So, I'm not sure what's different in these -- our approach to it is to, indeed, make sure there's a point of communication so they get the care they need.

The big problem -- I almost laughed when you said they had trouble getting specialty service. I said, oh, really? No kidding. That's the big problem --

MR. PERRY: Exactly.

VICE CHAIR SUNDWALL: -- because, we get them in primary care, but, my goodness, to get in queue to see an orthopedist or an ENT or -- it's very difficult and it takes a long time and we just don't have enough specialists that are willing to see them.

MR. PERRY: I think your point around the health plan, we thought the health plan, the managed care plan that they enrolled in, that that presence would come up more in the focus groups, and maybe it's because this was still early in the process. So, this was June, July. Maybe that first contact hasn't happened with the care manager or whatever. But, they didn't -- they weren't seen as an advocate.

They weren't seen as someone they could go to for information.

CHAIR ROWLAND: Other comments? I think this is very helpful, to always hear the voices of the beneficiaries and the issues that they face, because it helps us to inform where the gaps are and where the improvements can be made, so thank you very much --

MR. PERRY: Thank you.

CHAIR ROWLAND: -- and we look forward to round two, I guess, from Denise's comments, of continuing to really be able to find out what's going on on the ground. So, thanks again.

And, now, we'll move from the people's voices to the providers' payments, and we've got Jim Teisl who's going to come both explain to us the mandate that we have from Congress to look at this and our work plan for trying to accomplish that.

MR. TEISL: Thank you very much.

CHAIR ROWLAND: And he's last but not least.

MR. TEISL: That's right. Thanks for the plum time spot.

[Laughter.]

SESSION 6:

PLANS FOR NEW MANDATED STUDY ON DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

* MR. TEISL: So the purpose of this session is to provide a very brief refresher for you all of federal Medicaid DSH payment policy. This is a subject we've covered in some detail in previous meetings. It's just a refresher on the federal policy side, not new information, also an update on the Medicaid DSH allotment reductions that were included in the Affordable Care Act and originally scheduled

to begin in fiscal year 2014, and then finally an overview of a newly required MACPAC report on Medicaid DSH and some of the preliminary work that we've done to prepare for meeting our deadlines.

As a reminder, disproportionate share hospital payments, or DSH payments, are statutorily required payments to hospitals serving low-income patient populations. They are intended to improve the financial stability of safety net hospitals as well as to preserve access to necessary health services.

In fiscal year 2013, DSH payments accounted for over $16 billion in total Medicaid spending. This is a significant amount of money being spent on these payments.

For fiscal year '14, a total of 11.5, nearly $12 billion, was preliminarily allotted to states for DSH. Allotments ranged -- and this is also important. Allotment ranged from about $10 million or less in four states to over a billion dollars in three states, so there's a significant amount of variation in individual states, federal DSH allotments.

So hospitals must receive DSH payments from states if they meet criteria for higher levels of serving low-income individuals. They are often referred to as "deemed DSH hospitals," but states may make DSH payments to hospitals if they have a Medicaid utilization of just 1 percent. So, as a result and as you've heard before, there's wide variation in how states distribute their DSH payments, and state policy is likely due, at least in part, to the size of the allocation that they get from the federal government.

There is -- and it's not up here. There is a hospital-specific limit, again, that we've talked about before. A state's DSH payment to an individual hospital is limited to each hospital's Medicaid shortfall and the costs that they incur in serving uninsured individuals.

The Affordable Care Act included reductions in the total amount of federal DSH allotments, and that was based on an expected decline in the number of uninsured. Subsequent legislation has delayed

the onset of the reductions, which were originally supposed to begin in fiscal year 2014, to now fiscal year 2017, and it's also extended the reductions to additional years. The reductions are now scheduled to run through fiscal year 2024.

While the initial schedule would have allowed for several years of phase-in, the current schedule ramps up, as you can see here, very quickly, from a $1.8 billion aggregate reduction in the first year to nearly $5 billion in the second year.

Under current law, fiscal year '25 would revert to the pre-2014, or pre-2017 now, unreduced levels. However, the reductions have been extended each year since the enactment of the ACA.

CMS published a final rule that included a methodology for implementing the reductions, and they published the final rule prior to the delays in the onset of the reductions. So, in September of 2013, they published a final rule describing the methodology for implementing the allotment reductions, only for fiscal years 2014 and 2015. When they published that rule, they said it was only for those initial 2 years in recognition of the fact that current data regarding states' levels of uninsurance wouldn't yet reflect their decisions regarding Medicaid expansion.

So for fiscal year 2017, which is now the first year of the DSH allotment reductions, a new DSH reduction methodology rule is going to have to be proposed and then ultimately finalized.

The last bill that delayed the DSH reductions and then extended them through 2024, the Protecting Access to Medicare Act of 2014, also included some provisions requiring a new MACPAC report to be submitted to the Congress annually regarding Medicaid DSH.

The first report is due in February 2016. This may in fact be prior to CMS's issuing of a rule implementing the new reduction methodology. We don't know that for sure, but the reports are

required to include -- I am just going to go through each of them one by one -- data relating to changes in the number of uninsured, data relating to both the amount and sources of hospitals' uncompensated costs -- and there are some examples included in the statutory language, which each of you have in your packets -- data identifying hospitals, hospitals with high levels of uncompensated care that also provide essential community services -- again, some examples are provided -- and finally, state-specific analyses of the relationship between both current and projected DSH allotments and these data elements that are requested above. So that's all.

[Laughter.]

CHAIR ROWLAND: Simple tasks.

MR. TEISL: Yeah.

So in meeting the statutory requirements, we will be attempting to answer or at least inform discussion regarding several important policy questions, and we've listed some of those here. We, of course, welcome your thoughts regarding these policy questions, as well as others, that you may think are important for us to consider.

The ones that we include here are, What are the estimated effects of these DSH reductions, both at the state and the hospital level? Do the reductions appear to align with decreased numbers of uninsured and reductions in uncompensated care? And then to what extent can existing data sources be used to provide information, as required by the statute?

Here, we lay out our approach. So the first thing that we want to do is evaluate the availability, the completeness, and relevance of potential data sources. We intend to construct an operational model that will allow us to estimate DSH allocations, and our initial intent is to estimate DSH

allocations based in large part on what CMS proposed in the rule that would have implemented the reductions for 2014 and 2015.

We intend to attempt to estimate state- and hospital-level DSH allocations based on various data sources and assumptions. We intend to, and we have already begun, to consult with stakeholders throughout the process, including representatives of the provider community, different responsible federal agencies, states themselves, and the research community.

We, again, have initiated this work in addition to meeting with stakeholders. So far, we have also initiated a contract to build the DSH allocation model that will allow us to prepare these estimates. We are currently in the very early sort of planning stages for the project. I would emphasize that, as always, data sources are going to present a major challenge for us in doing this work.

As you've heard before, annual DSH audit report data are the best source of provider-level DSH payments, but they are not available generally until four years after the payments are made. Further, statute requires that we examine the relationship between DSH allotments and a variety of factors that are not included in the DSH audit data. Examples of these include things like bad debt, under-reimbursement from non-Medicaid payers, these essential community services that I mentioned. So, as a result, we plan to examine the utility of other potential sources, possibly including but not limited to Medicaid cost report data, IRS data, the Schedule H Form 990, provider survey data, and possibly other sources.

We will, of course, keep the Commission updated as we progress. As we work through this process, we intend to sort of come to you to share our findings and sort of seek your direction on next steps.

We hope to have a functional and validated preliminary model by the end of this year, at

which point, hopefully, we'll be able to start to share our findings.

CHAIR ROWLAND: Andy?

COMMISSIONER COHEN: Good luck, Jim.

[Laughter.]

COMMISSIONER COHEN: This is really hard, but I have to say one thing that has always seemed particularly challenging about this whole issue, and it's methodologically, not substantively, which is very challenging, too, because it's a lot of money that is going to go away that hopefully, largely, in most states goes to the safety net providers, but not always and not in all states that it largely goes there.

I think the challenge is that -- and I wanted to ask you -- if you have to do hospital-specific modeling and you can only do that based on audits, so that's what has happened, I have always assumed that whatever a state's sort of methodology is for distributing DSH payments, it is likely because that is a flexible and the state has some control over. That will change when the number of dollars available change.

So do you have a way -- so by using what they got under a more-money scenario, do you have any way to actually sort of build into your model what their actual, maybe, new policy is on distribution, or is that just sort of too granular for us to be able to do it at a state-by-state level to really understand it?

MR. TEISL: It's our intention to do our very best. It's going to depend on assumptions that we make regarding changes in state policy.

In the statutory requirements regarding the reductions, CMS is supposed to look at the extent to which states target their DSH payments currently, and larger reductions are to be applied to states that don't target the payments as much to hospitals serving the highest numbers of low-income individuals.

As a result, you might expect that as the reductions start to be implemented, states are going to change their policies, in some cases.

What our plans at this point are is to try to put sort of bounds on our assumptions and consider what the effects might be, if all states move to target optimally versus sort of staying at current levels of targeting.

This isn't going to be easy. This is obviously part of the stakeholder involvement process that I talked about, but it is something that we want to try to mount.

CHAIR ROWLAND: Trish, then Patty.

COMMISSIONER RILEY: I echo the good luck because it's important.

It strikes me that the underlying cost of hospitals is sort of fundamental here, that we make some assumptions. I always look to under-reimbursed. By whose judgment is it under-reimbursed as opposed to too high costs of hospitals? Can you address that in any way? And we certainly know from the Health Affairs articles, there's lots of inefficiencies.

And the second question is, Will we know anything about the rise of bad debt due to high-deductible plans? Because a lot of what's happened to these hospitals is pre-ACA. The high-deductible plans meant more and more people couldn't pay their out-of-pocket costs.

MR. TEISL: To be determined, but bad debt is actually a good example of a data element that we can't get currently from, for example, the DSH audit reports and why we will need to look to other sources of data like, for example, the Medicare cost reports.

CHAIR ROWLAND: Patty.

COMMISSIONER GABOW: One source of data for bad debt might be useful. I'm not

sure that it's validated, but at least in Colorado, the hospital association got reports from every hospital, and they published. I mean, it was available. Medicaid, Medicare, bad debt, charity, which often really you can't tell which should be, so you may have to lump them together.

But at least my guess is that some state hospital associations report that. Again, you'd have to ask how to validate that, and I don't know.

I think one piece I would add to your work plan is since we know that the effect on the DSH reduction is going to have a differential impact in expansion versus non-expansion states of the safety net, I would suggest if you can work this into your methodology, is to take a set -- I don't know -- six, eight, whatever, safety net hospitals, like four in an expansion state and four in a non-expansion state, and try to get current data that you wouldn't be able to get from the report and really look at what's happened to the buckets -- Medicaid, uninsured, bad debt, charity -- and the DSH payment reduction and what the impact of that would be. I'd take sort of a granular look at a few in both kinds of states would really inform what's going to happen. I think it would be useful, and the data lag is so long, otherwise.

The last question, is there any reason to think that the methodology that CMS -- you may not be able to answer this -- CMS laid out when they assumed the cuts would come in 2014 is going to be a different methodology, now that the cuts were simply delayed?

MR. TEISL: I wouldn't want to speculate.

COMMISSIONER GABOW: That's what I thought.

[Laughter.]

COMMISSIONER GABOW: But there's no intrinsic reason. Nothing changed about the law, except the delays; isn't that correct?

MR. TEISL: Right.

CHAIR ROWLAND: You know, this is clearly an area, as Patty has just pointed out, where available data may not obviously answer any of the questions that we need to answer and where using the Commission's research resources to do our own survey or our own case studies of selected facilities may in fact be critical to being able to provide informed information on this.

So since Anne is not here, I will commit to having you be able to recommend some uses of our resources to address some of the issues on your plate.

MR. TEISL: Perfect.

CHAIR ROWLAND: Herman, did you have a comment?

[No response.]

CHAIR ROWLAND: Mark?

COMMISSIONER HOYT: Sort of following up on that comment Trish made, I had the same thought. There's sort of an assumption that's embedded here that if you do a lot of business with Medicaid, then you need help because Medicaid is a lousy player, the 25 percent or however that's expressed. So they're asking you to chase down all these things that aren't paid for. In my mind, it seems like this wouldn't be for you to do, but it may be food for thought for us in terms of a recommendation.

Why are we still not figuring out all of the funding streams into the hospital that Medicaid does pay for, whether it's direct reimbursement or it's from the managed care plans or DSH money, supplemental payments, taxes? Even if it's at an aggregate level across the whole state, if we can't get it by hospital, but they're looking for something that's obviously pretty granular here. It seems to me like we could turn it on its head and go after what Medicaid is paying for and try to sort that out and see how it

compares to commercial or Medicare, whatever the bar is that they like.

CHAIR ROWLAND: Other comments?

[No response.]

CHAIR ROWLAND: Well, we have a big task ahead of us, and I think Jim has given us some insight into a good plan to proceed.

And with that, I will end this session and ask if there are any comments from individuals from our audience who would like to offer any insights or guidance to us.

PUBLIC COMMENT

[No response.]

CHAIR ROWLAND: Then I think I will thank everyone for joining us today, and this session of our MACPAC meeting is adjourned.

[Whereupon, at 11:40 a.m., the meeting was adjourned.]