MACPAC

Medicaid and CHIP Payment and Access Commission

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

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

Thursday, November 14, 2013
9:00 a.m.

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

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

Session 1: The Future of CHIP: Views from CHIP Directors

Cathy Caldwell, Director, Children's Health Insurance Program, State of Alabama....4

Colleen Sonosky, Associate Director, Department of Health Care Finance, District of Columbia....10

Rebecca Mendoza, Director, Division of Maternal and Child Health, Commonwealth of Virginia....13

Session 2: The Future of CHIP: Part II

Joan Henneberry, Principal, Health Management Associates....34

Tricia Brooks, Senior Fellow, Center for Children and Families, Georgetown University Health Policy Institute....39

Session 3: Long-Term Care Commission: Report from the Commission's Leadership

Bruce Chernof, President & CEO, the SCAN Foundation....62

Mark Warshawsky, Adjunct Scholar, American Enterprise Institute....74

Session 4: Short- and Long-Term Issues for CHIP

Chris Peterson, Director of Eligibility, Enrollment, and Benefits....90

Public Comment Day 1....141

Adjourn Day 1....145

Day 2....146

1 P R O C E E D I N G S [9:12 a.m.]

2 CHAIR ROWLAND: Please, convene. Okay. I'm pleased to call to session this meeting of the
3 Medicaid and CHIP Payment and Access Commission and to actually begin today's discussion and the focus
4 of our discussion today on the CHIP part of our mandate, so that we're going to welcome our first panel.
5 But first I'd like to turn to my Vice Chair to offer his welcome.

6 VICE CHAIR SUNDWALL: Well, welcome. We're delighted to have you here today and as you
7 can tell, we're kind of honing our efforts now at this meeting and subsequent ones, really on CHIP and the
8 ACA implementation, some long-term care issues, but CHIP is on the minds of all of us. We've already had
9 a rich discussion this morning before you came, so we look forward to some details from those of you who
10 are on the frontlines, if you will. Thank you.

11 CHAIR ROWLAND: And welcome and I'm going to turn our Commissioner member, Sharon
12 Carte, to introduce our panel, but I'm very delighted to have our CHIP Directors with us. Sharon.

13 COMMISSIONER CARTE: Thank you, fellow Commissioners. It's my pleasure to introduce to
14 you three CHIP Directors, first starting with Caldwell. Cathy is the Director of the Bureau of Children's
15 Health Insurance for the State of Alabama where she's been for over nine years. In that capacity, she
16 oversees all the fiscal data management and administrative activities for Alabama's separate CHIP program.
17 Cathy has her master's degree in public health, maternal and child health since 2000 from the University of
18 Alabama at Birmingham.

19 Next, we have Colleen Sonosky, and Colleen oversees the Medicaid expansion CHIP program for
20 the District of Columbia where she serves as Associate Director of the Division of Children's Health
21 Services in the District's Department of Health Care Finance. Colleen has her public policy health policy
22 background for over 20 years and has served with CHIP for 4 years and that also includes among her duties
23 overseeing the District's EPSDT, Early Periodic Screening, Diagnosis and Treatment program for the
24 Medicaid kids. Colleen is also an adjunct assistant professor for community health and preventive services
25 with George Washington University School of Public Health and Health Services.

1 And last, we have Rebecca Mendoza. Rebecca is the Director of the Division of Maternal and Child
2 Health for the Commonwealth of Virginia within Virginia's Department of Medical Assistance Services.
3 There she serves as the Director of Virginia's combination CHIP program, and she also has responsibilities
4 for the EPSDT for Virginia as well and for the baby care programs for high risk pregnant women and
5 infants. And Rebecca has worked within that division for over 10 years. She has received her master's
6 degree of sociology from the University of Tennessee.
7 So, we have three very experienced directors to give you three different flavors of CHIP today.
8 CHAIR ROWLAND: Thank you very much. We're going to turn first to Cathy Caldwell to share
9 with us her experiences. Thank you.
10 **### SESSION 1: The Future of CHIP: Views from Chip Directors**
11 * MS. CALDWELL: I'm delighted to be here and please, if I go down trails that you don't
12 understand what I'm talking about or I use acronyms that aren't plain, please stop me and ask questions,
13 redirect. But I'm here primarily to talk about Alabama's Separate CHIP program, just give a little bit of
14 history and try to quickly bring it up to date and point out some of the most important issues that we're
15 facing.
16 But I first want to say we're very, very proud of our CHIP program in Alabama. It has been one
17 area where there's been great success. It's a very popular program with families, with the political leadership,
18 with the providers in the state as well and also very proud to say that Alabama was the first state in the
19 country to have our CHIP plan approved.
20 We began our CHIP program as a Medicaid expansion just for the adolescents. I believe at that
21 point in time, (inaudible) Medicaid was up to 13 years of age in Alabama, so we used our CHIP funds to
22 expand Medicaid to adolescents up to 19 years of age up to 100 percent federal poverty level. And so that
23 expansion lasted for a few years and so the Medicaid expansion piece of Alabama's CHIP was phased out
24 after a few years of the program.
25 But then our Separate CHIP program began in October of 1998. It is a private insurance model

1 Separate CHIP administered by the Alabama Department of Public Health, so in a separate state agency
2 from Medicaid. And there were several reasons that the program was actually put in public health and
3 several reasons that it was implemented as a private model. Our Medicaid program at the time not only had
4 very low reimbursement rates but also a very slow payment, and so there were a lot of physicians who were
5 -- particularly pediatricians, who had some very, very difficult financial times because of some problems
6 going on in Alabama Medicaid, and so they were very vocal that they wanted CHIP to be structured
7 differently than the Medicaid program was at that time.

8 Now since that point in time, there have been some improvements in Medicaid, and I think that the
9 Separate CHIP was very influential in that. I think some of the more innovative approaches that we took in
10 CHIP led to some changes in the Medicaid program as well.

11 Benefits for our Separate CHIP -- and our Separate CHIP is called All Kids -- so I'll use All Kids
12 and CHIP interchangeably, but I'm talking about the same program. Benefits are delivered through Blue
13 Cross and Blue Shield of Alabama which is the insurance carrier who covers 85 percent of the insured
14 individuals in our state. So it's the same insurance plan, same network that almost every privately insured
15 individual in our state uses. The network includes 100 percent of the hospitals in the state, 95 percent of the
16 physicians, 75 percent of the dentists. So access is not an issue except for the, you know, pediatric
17 specialists that they're just too few in our state. But virtually all providers in our state are in that network
18 and our CHIP program goes up to 300 percent FPL. We were at 200 percent FPL and about 5 years ago,
19 we expanded to 300.

20 So some of the policy choices that we had to make early on: overarching all decisions that we made.
21 We wanted to make decisions that were family friendly; certainly, being compliant with regulations but
22 always thinking what's going to be the easiest and the best for the family, you know, trying to set up a
23 system that didn't look like a big bureaucratic program and a program that was easy to navigate. So we tried
24 to, you know, make all of our decisions really with that guiding philosophy.

25 We have always accepted self-attestation for most of our application information. Early on, we

1 required verification of birth date and that truly was because there seemed to be some political forces that
2 wanted us to verify something. And then several years into the program, we realized of all things, you
3 know, to verify -- and I call it verify birth date -- we used to say we were verifying birth, and I thought, you
4 know, it actually made no sense at all. So we did away with that.
5 We always wanted to align as closely as possible with Medicaid, so even though some of the
6 processes were different, we wanted eligibility to align seamlessly so that no children fell between the cracks.
7 For example, early in CHIP, we did not have any income disregards, so we realized that since Medicaid did,
8 depending on which door the applicant went through, you could get different eligibility decisions. So we
9 put in place the same income disregards that were in place with Alabama Medicaid. We have always had a
10 joint application with Medicaid, both paper and then later we implemented a web-based application and
11 then a few years later implemented an electronic signature on our web-based application. So even though
12 we're in separate state agencies, we've always tried to align and very closely coordinate.
13 We also have always -- until two years ago, we've always done a lot of outreach and education in
14 Alabama focused on all uninsured children in the state. And we saw, like many states did, that netted more
15 children enrolled in Medicaid than it did CHIP because there were so many children in our state who were
16 uninsured but eligible for Medicaid, just for a variety of reasons were not enrolled. We actually discontinued
17 outreach almost two years ago and it was because of state funding issues, and I'll touch on that in just a
18 minute.
19 We've always had cost-sharing in our program. Our legislators have always liked the fact that we
20 had cost-sharing, just always thought that it was a good thing that families contributed to the cost of the
21 coverage. We have an annual premium and I think we're still the only state that has an annual premium. It
22 works well for us. Children enrolled have the entire 12 months to pay their premium and actually, with the
23 grace period, they have 13 months. So early on, it was only the higher income tier that had premiums. Now
24 all enrollees except Native Americans do have premiums. Currently, they're either $52.00 a year or $100.00
25 a year. And we have copayments as well on most non-preventive services.

1 For our crowd-out prevention strategies, we have a 90-day waiting period if group insurance is
2 voluntarily terminated. And we have some exceptions to that. If the child reaches his or her lifetime max in
3 their private insurance, they can drop with no waiting period. If the coverage is COBRA, they can drop it.
4 So we are discontinuing that 90-day waiting period effective January 1. In this, what I call "The New
5 World," a waiting period in CHIP just makes no sense at all, so we are discontinuing it. Plus we felt that it
6 would be -- with the new mandated exceptions, we felt that it would be nothing but administrative burden
7 on us. Very few children would have that applied, so we are doing away with it.
8 So bring up to current day. We have some huge state funding issues. In Fiscal Year 13 which, thank
9 goodness, we made it through, our state allocation was just way less money than we needed, actually about
10 40 percent less state dollars than we needed. Because of the maintenance of effort and the Affordable Care
11 Act, we no longer had the budget control strategies that we had had previously. We cannot put a waiting list
12 in place. We cannot roll back our eligibility levels. So the strategies to balance our budget are very, very
13 limited. So some of the things that we did: we increased premiums by the maximum allowable amount
14 which was 4 percent, so our premiums went from $50.00 to $52.00 and from $100.00 to $104.00. We did
15 increase co-pays and some of them increased substantially, because that was not considered part of
16 eligibility, therefore not subject to maintenance of effort. And we had a good bit of room between our
17 current co-payments and what was allowable under regulation. So we have increased our copayments.
18 So we were able to make it through Fiscal Year 13. We have some state budget issues in this current
19 fiscal year and I'm sure in next fiscal year. We've about run out of options so, you know, if we don't get
20 what we need, I think the only option is to be in violation of maintenance of effort. But we have certainly
21 articulated that to the leadership in our state.
22 So one big unknown along those lines is the difficulty in quantifying what we think the effects of the
23 Affordable Care Act will be on enrollment. There are many, many moving pieces. We will get additional
24 children in CHIP, we think, where their parents are eligible for a premium tax credit, but the family income
25 is within our CHIP range so the children will be enrolled in CHIP. You know, we've come up with

1 estimates. We've worked with our actuaries but until we start getting actual data and start tracking based on
2 what we see with enrollment, it's really just sort of a guess. MAGI methodology versus the way we currently
3 do it. I mean there will be children that move from one program -- you know, there will be back and forth
4 movement. So we're anxiously awaiting that. But if it causes a drastic increase in CHIP-funded children
5 enrollment, certainly that will compound our budget issues.
6 We are working on transitioning approximately 25,000 enrollees to Medicaid from CHIP effective
7 January 1, and this is because of the requirement in the Affordable Care Act to have Medicaid coverage for
8 children up to 133 percent FPL. Currently, for children 6 to 19 in our state, Medicaid's up to 100 percent
9 FPL and then CHIP's up to 300. So we are working on transitioning those children. We have a lot of
10 concern over network adequacy in the Medicaid program as well as assignment of primary care physicians
11 that takes place in Medicaid, but we don't have it in CHIP, that happening with so many children at one
12 time. Every month through the enrollment process, there is a certain group of children that transition from
13 CHIP to Medicaid, but this is just a lot more at one time.
14 About a year-and-a-half ago when we were dealing with ways to live with our state Fiscal Year 13
15 allocation, we explored the option of delivering our CHIP benefits through Medicaid as opposed to through
16 a private model. We really weren't considering becoming a Medicaid expansion. We were still going to be a
17 Separate CHIP but just delivery through the Medicaid networks and actually, we were real close to making
18 the decision to do that with the assumption that Medicaid rates were lower than the rates we pay which we
19 pay off the commercial fee schedules, Medicaid rates were lower; therefore, it would be less expensive to
20 deliver benefits through Medicaid. And after months of discussion, long discussions, we actually concluded
21 that we didn't think we were going to save any money by doing that because yes, outpatient rates were
22 lower. Inpatient rates, when you look at the very complex system of financing Alabama Medicaid,
23 intergovernmental transfers and, you know, the involvement of DSH funds and CPEs and all the
24 complicated formulas used to fund Alabama Medicaid, on the inpatient side, the net is Medicaid
25 reimbursement is higher and actually fewer utilization controls on the inpatient side than on the outpatient

1 side.

2 Now I'm a public health professional and so when we're figuring this out and we realized that the
3 incentives were actually towards inpatient instead of outpatient, you know, inpatient instead of preventive,
4 and so when you look at some of the incentives, some of the -- you know, with Blue Cross Blue Shield of
5 Alabama, we get pretty good pharmacy rebates and there are real good utilization controls and those type
6 things. There was actually -- we came to the conclusion that we weren't going to save any money by going
7 that route, so we kept our private delivery model, and we continue to do so.

8 Like I said, our biggest issue is state funding and there's no serious discussion in the state about
9 going to a Medicaid expansion model instead of a private delivery model, I think mainly because of exactly
10 where I started. There's been great success in our private model. The legislators, the governor are very
11 much in support of our model, just some very real state budget issues and, you know, tough decisions to be
12 made.

13 So I hope I covered all the points that I was asked to cover, but certainly I'm looking at Chris.
14 Shout out if there were any that I missed, but I would be --

15 CHAIR ROWLAND: Cathy, could you just clarify how many children are covered by your CHIP
16 program and what share of Alabama's children (inaudible) --

17 MS. CALDWELL: Absolutely. Approximately 85,000 children are covered in Alabama CHIP as
18 compared to Alabama Medicaid that covers close to half a million. Between the two, and I don't have the
19 exact percent in my head, but I think between the two, that's in excess of 50 percent of the children in
20 Alabama. It may be close to 60 percent. Now, when we were actively doing outreach and education, our
21 enrollment was a little bit higher. It has declined by probably about 1,000 children over the last 24 months.
22 I would anticipate if we had continued, you know, that level of outreach, our enrollment would be several
23 thousand higher than it is now.

24 CHAIR ROWLAND: Thank you.

25 MS. CALDWELL: You're welcome.

1 CHAIR ROWLAND: Colleen.

2 * MS. SONOSKY: Thank you. Good morning. Thanks for inviting me. Chris asked me to
3 come today -- I'm not very far from my office -- to talk about CHIP as a Medicaid expansion. And as
4 Sharon mentioned, I've been with the District of Columbia Department of Health Care Finance for about 4
5 years now overseeing the EPSDT benefit and children's health services. And the one thing that I would say
6 has been constant since day one is the seamlessness of CHIP and Medicaid and all just being seen as
7 together and as being seen as the Medicaid program.

8 So my next slide is primarily around the Medicaid program in the District of Columbia, and we have
9 offered a comprehensive benefit package for both children and adults. It's a program that is well over $2
10 billion for the District and one of the largest pieces of the budget and our FMAP is 70-30 percent rate.

11 The Department of Health Care Finance is, I would say, a relatively new agency. The history in the
12 District had been with the Medical Assistance Administration in the Department of Health, but about 5
13 years ago, the MAA came out of the Department of Health and the Department of Health Care Finance
14 was created to oversee the Medicaid program, and within that, CHIP as a Medicaid expansion is part of the
15 Department of Health Care Finance. And we also have two locally funded programs: the Health Care
16 Safety Net Alliance and the Immigrant Children's Program which is also something that -- those children
17 receive the EPSDT benefit also but it's paid out of completely local funds.

18 On eligibility determinations, they are run through our Economic Security Administration and the
19 Department of Human Services, so there's always that coordination between a Medicaid agency and a
20 Human Services agency, making sure that we're all on the same page, and there are always -- challenges have
21 been in the past and continue with some of the health reform activities. But our working relationship with
22 ESA continues to make sure we enroll as many individuals as possible. I mean with that, the District covers
23 many people. One out of every three District residents receive either Medicaid or the Alliance program.

24 And then children in the District, which is primarily where my division focuses on, over 40 percent
25 in DC Medicaid are children. For a good number of years, the District has had low numbers of uninsured.

1 We've always been at the top of having high insurance rates, and our enrollment in Medicaid and CHIP
2 increased by 13 percent between 2008 and 2010. That primarily comes out of we have high participation
3 rates in public insurance. For the children who are eligible, we have 95 percent of them enrolled, and that
4 has been something that has continued and is a report that comes out from Urban Institute on an annual
5 basis.

6 In FY12, on our CMS-416 Reports, we reported about 97,000 children enrolled in Medicaid and
7 CHIP, and in thinking through those numbers, that's about 80 percent of the District's children enrolled in
8 the Medicaid and CHIP program. And to break down the CHIP children, it ranges monthly but it is
9 generally around 6,000 to 6,500 on a monthly basis.

10 And again, as I said, all beneficiaries receive the full EPSDT benefit, and that's either through a fee
11 for service arrangement or managed care. Most of our children are in managed care arrangements and that's
12 well over 90 percent of the children. And with the EPSDT benefit, that's up until their 21st birthday.

13 So this slide just focuses on what the eligibility levels are. And with the CHIP expansion, we went
14 up to 300 percent relatively early on in the CHIP days, and that is what has led to our great coverage
15 throughout the years for children. And in my role at DHCF, the one thing that I continue to say to the staff
16 working on health reform is as long as kids continue to be enrolled and eligible for the Medicaid program,
17 I'm happy. If that's changing, you need to let me know. And they continue to tell me that all kids are
18 staying. We are not thinking that we are losing children into any aspect of going to the exchange or any
19 other type of coverage, so all of our MAGI methodology work is to keep all the children who we have
20 enrolled now continue to stay enrolled with us.

21 With other aspects of health reform, because our insurance coverage for both children and adults is
22 very high, a large part of our focus has been on more of the service delivery and technology aspects. And
23 the District has its own exchange called DC Health Link. We have had some glitches but it is continuing to
24 move forward and we have been enrolling folks. And from what my understanding is, about 85 percent of
25 the applications coming in are childless adults which really makes sense since we already have so many

1 children already covered. And many of the other activities around health reform are health homework and
2 all of the work going on in the HIT and HIE infrastructure for the District.
3 And in our service delivery, again, I just wanted to mention that most of our kids are in managed
4 care, so it's well over 90 percent. We have three full risk managed care programs with a new contract that
5 started on July 1st of this year with AmeriHealth DC, MedStar Family Choice and a new plan that has just
6 come into the District called Trusted.
7 And then the District also has for children who are eligible for SSI or who are SSI-like can enroll in
8 a special needs plan. It is not full risk but it does provide the full EPSDT benefit as well as enhanced care
9 coordination for these pretty medically fragile children. And those children also go up to the age of 26. So
10 that's the Health Services for Children with Special Needs plan in the District.
11 And then about approximately 10 percent, maybe a little less, are fee for service children and those
12 are mostly our foster care children, children living in long-term care institutions and children who are
13 disabled but opt out of the HSCSN.
14 So one of the main things that I focus on is sustaining EPSDT or the Medicaid benefit for children.
15 And that's -- I always try to break it down into three components and thinking about making sure that we're
16 doing everything we need to do on access to services, for informing our beneficiaries about the benefit and
17 making sure that they can get to their services in terms of transportation and scheduling and any translation
18 services as well as when they are in a well-child visit, making sure that our providers have a full
19 understanding of what they need to do with physical, mental health and developmental assessments.
20 A large part of the work that I do now is integrating primary care with mental health, developmental
21 and oral health. And a large part of that goes to the Anticipatory Guidance part of EPSDT which has
22 always been a part of the statute and making sure that parents understand all the developmental phases of a
23 child's life, and then getting to the next part of the Medicaid benefit for children, which is any follow-up or
24 diagnostic services that are needed for children and making sure that that reality comes into fruition, because
25 sometimes the T part of EPSDT is actually the hardest, especially when it is a service that is not in our state

1 plan and how we need to make sure that that service is still provided for for those children.

2 So Chris kind of asked me to look at, you know, post 2015 and thinking about if CHIP would go

3 into Medicaid, what that would mean. And as I think I've described, with being an expansion state, we

4 really will not see very many differences. I mean the seamless coverage of Medicaid and CHIP, everything

5 would still remain the same for our children in terms of service delivery. We don't have any waiting periods.

6 We don't have any cost sharing or premiums, so none of that would really change. I mean I think one thing

7 would be is if there is a budget pressure because the enhanced FMAP would not be there. And with some

8 of our policy research staff, we just looked at the differential if those 65 or 7000 children, we were not

9 receiving the enhanced FMAP and it would come to probably about 1.5 million for those children. So it's

10 something that we would have to address, but in terms of service delivery, we really would not see any

11 major difference.

12 And then this last slide is just things that I think I've touched on already in terms of what our focus

13 areas are in DC for FY14; a large focus on what a child is actually getting in a well-child visit and making

14 sure we're integrating primary care with mental health, developmental health and oral health services. And

15 there's always working with the school system and what children getting between the school system and the

16 health system. And then one thing for that 10 percent of children in fee for service who do not have all the

17 same supports in the managed care program, to make sure that we're looking at what a real comprehensive

18 picture of those children are to be able to address their needs. And those are the issues that I've been

19 working on.

20 CHAIR ROWLAND: Thank you, Colleen. And now we'll turn to Virginia. Rebecca.

21 * MS. MENDOZA: Good morning and thank you so much for having me here to talk about

22 one of my favorite topics, our CHIP program in Virginia. I'm going to go over -- these first few slides are

23 kind of our history of where the program has been, and I won't go over every bullet but they're there for

24 your reference in case you want to ask some questions later.

25 Our Separate CHIP program started in 1998 but it was a Medicaid look-alike. It went up to 185

1 FPL and we used basically the Medicaid income methodology but we had 12-month waiting period, and
2 because of this and some other reasons, we had very low enrollment in those first years and we were actually
3 returning some federal dollars. And so the legislature stepped in and created a separate program and
4 renamed our program, a truly separate program. They also raised the income limit to 200 percent but made
5 it a gross with no income disregards, also shortened the waiting period to only 6 months and used the state
6 employee benefit package but also added cost sharing, so co-pays for most services plus monthly premiums
7 of $15.00 per child per month and up to $45.00 per family per month, which at that time was one of the
8 highest in the country. There was also a strong focus on outreach at that point in time.
9 In addition, at that time, we introduced a Central Processing Unit moving our program from a very
10 traditional case-based worker model to a more production model. We utilized a contracted vendor to bring
11 in technology, a new eligibility system, et cetera.
12 But the premiums were still there early on and we started to see that we were going to be
13 disenrolling more people than we were enrolling, and so that was quickly halted and the premiums were
14 removed in 2002. Also in 2002, we became a combination state because we created the MCHIP program
15 for those children 6 to 18 from 100 to 133 much like is being done right now with Separate CHIP programs
16 for the ACA.
17 Over the years, we've made a lot of tweaks and enhancements. In 2003, we lowered the waiting
18 period again to 4 months which is what it is currently. We also implemented a waiver program for pregnant
19 women through CHIP because we knew that we were getting these newborns but they had to go through
20 the application process and some of the moms weren't able to get prenatal care, but we were getting the kids
21 enrolled after the mother not getting prenatal care, so we started the prenatal care program. And we also
22 changed our premium assistance program from the state plan option which had a lot of administrative
23 burden to a more streamlined process, easier for families, easier to administrate for premium assistance.
24 We continue to make enhancements to streamline eligibility and enrollment through use of online
25 application in 2005. Then we implemented telephonic applications, telephonic signatures in 2011 and many

1 things in between. But this year, before -- well, basically this year, we had about 55 percent of our new
2 applications were submitted online with an e-signature and 20 percent were submitted telephonically with a
3 telephonic signature in our Separate CHIP program.
4 So this is a history of our point-in-time enrollment and just over half of the children we have
5 covered through CHIP are covered through our Separate program. We're at about 115,000 at any point in
6 time during the year, kids covered through MCHIP or SCHIP, you know, the combination of the two. Our
7 CHIP program, MCHIP and SCHP combined, account for about 19 percent of the children that we cover
8 through all of our programs, Medicaid and CHIP programs in Virginia, so it's a significant number of
9 children.
10 We are an early adopter MAGI state so we did start on October 1 using MAGI methodology. We
11 also are an FFM state. We implemented a new E&E system on October 1 and this is causing us to end our
12 Centralized Processing Unit operations in January as things are moving back to the new system.
13 Our eligibility range for our Separate CHIP program has decreased now because of the MAGI
14 conversation, so we're 10 percentage points less than we were in the range, and that's because our upper
15 income range did not get adjusted because we did not have any disregards. So our lower end got brought
16 up but our upper end did not, so we lost 10 percentage points.
17 Our pregnant women's program, because there's now going to be coverage through the exchange,
18 the legislature last session ordered or asked us to end it, so starting in January, we will no longer be enrolling
19 women in the pregnant women's program.
20 I think some of the benefits of our program overall is that CHIP has been kind of the test kitchen
21 for many different strategies, whether it was outreach and enrollment, whether it was streamlining and
22 policy changes, whether it's use of technology, and we were able to have the flexibility to try many different
23 things. It's been a very successful bridge program. We've actually done surveys with families and they've
24 identified that this program has been a bridge program for them between, you know, Medicaid and getting
25 private health coverage.

1 The focus on children's health has been invaluable. Because it's a child only program, except for the
2 pregnant women which we still were kind of linking the two, it's really helped us even focus more on
3 children's health in the Medicaid program as well.
4 The flexibility overall in administering the program operations, that we are able to utilize contractors
5 much more easily than we can with the Medicaid program to help process applications and leverage
6 technology to improve efficiency and streamline processes.
7 Even state plan changes, those are much easier, benefits more flexible, you know, ability to do the
8 cost sharing which, as Cathy mentioned, that has been very popular in Virginia, at least the co-pays, if
9 nothing else, that families have some skin in the game and it makes it much more a bipartisan program. The
10 focus on outreach and enrollment has really, I think, really changed the dialogue and made the conversation
11 much more applicant-enrollee centric which we did not have before. And that bled over into the Medicaid
12 program, too, and really has helped get some changes made in the Medicaid program. It's bled over.
13 And, of course, as Colleen mentioned, the enhanced match is a definite carrot, you know, that we
14 can test some of these new things and have an enhanced match, because our Medicaid match in Virginia is
15 50-50, so, you know, we're at the lowest tier of that rate.
16 I think some of the challenges moving forward for us is that we are going to transition our
17 centralized cases back to 120 different departments of social services, local departments of social services.
18 And so we're almost kind of going full circle back to the model that we were in the beginning. And another
19 big challenge is that the Commonwealth is very much focused on horizontal integration of the benefits
20 programs, so TANF and SNAP and Medicaid and CHIP, you know, all the horizontal integration, whereas
21 with the ACA, it's much more of a focus on the vertical integration of the exchange, CHIP and Medicaid.
22 And sometimes getting those two different models lined up is a challenge. And we'll, I think, continue to
23 see some of that coming up as we go into Phase III of our new E&E system in 2015 and 2016 which will be
24 bringing in the TANF and SNAP cases into the new E&E system.
25 Maintaining an uninsurance waiting period, as I said, we still have the 4-month and we will still have

1 it through at least July 2014 because it's going to go through the General Assembly process to make a
2 change there. So I think that, in this new world, as Cathy said, you know, these children are the only
3 children that are going to have to go through the waiting period, and we have to do all the administrative
4 work to say that they've met an exception.

5 The affordability and family glitch issue, even with pregnant women which is kind of a different
6 version of the family glitch, you know, that not being an exception to enroll outside of open enrollment,
7 pregnancy, I think that there are some issues there with coordinating, and the coordination with FFM has
8 been more challenging than I think we all thought it was going to be, like we still don't have our referral
9 cases yet. So that's, you know, going to be a big workload that comes all at once, to process these --

10 CHAIR ROWLAND: For those who might wonder, FFM is the Federally Facilitated Marketplace
11 that we've heard so much about in recent days.

12 MS. MENDOZA: Yes. Sorry about that. But I think we will be in a place to be a bridge program,
13 to continue to be a bridge program for children through this transition, to focus the light on children's
14 health-related needs, their health insurance enrollment, their benefit package. But our biggest challenge is
15 just the lack of certainty about the future of CHIP and which path we're going down. I think that makes it
16 hard to have real substantial conversations about what to do with children in our state.

17 CHAIR ROWLAND: Thank you all very much. I think this has been very helpful to see the
18 differences across your programs and the similarities and the challenges. I'll take questions. I'll start with
19 Denise.

20 COMMISSIONER HENNING: This is for Ms. Mendoza. I was really happy to see somebody
21 from a CHIP program that also covered pregnant women because to me, that's fascinating having -- being a
22 nurse midwife. Is your CHIP program -- the coverage for pregnant women, is it mostly picking up people
23 that make too much money for Medicaid but don't have insurance coverage, or does it cover also
24 undocumented women and covering them because their children will become citizens when their born?

25 MS. MENDOZA: The last question is no because we have not chosen to do the unborn state plan

1 option. We have a waiver to cover the pregnant woman, and so all the same eligibility rules for who's
2 eligible apply. So undocumented, we do not cover. The legally residing pregnant women, we did take up
3 that option so we cover the broader range of legally residing alien residents.
4 COMMISSIONER COHEN: One thing -- and I'm going to make some like gross generalizations
5 here so you should both correct me and understand that I know they are gross generalizations but, you
6 know, one of the big changes that has happened since CHIP started is that the managed care environment
7 has changed quite a bit. So in the '90s, I think there were probably fewer children in managed care at all and
8 the nature of the plans that were covering them, there were probably -- actually, I'm not certain about this --
9 but I think there were more Medicaid only or sort of Medicaid specific plans. So I'm kind of -- I'm
10 wondering in your experience a little bit about the alignment of plans. So in your states, do the same plans -
11 - so we heard in Alabama that there is one very dominant plan and it covers almost all of the commercially
12 insured population as well as the CHIP population. Do they also -- are they also in the Medicaid program?
13 And then in the other states, do you have the same plans? And when I say "plan," I guess I should
14 be really clear. I mean sort of the large sponsor organization behind the plan. Are they aligned across your
15 various programs, meaning Medicaid and CHIP and maybe to some extent commercial? Has that changed
16 over time?
17 And then I guess a second part of that question is how much does it, in your experience, matter
18 whether the sponsoring organization is the same, or is there something kind of unique about having a
19 product line or a plan that is focused specifically on children to the extent that you have them?
20 MS. CALDWELL: In Alabama, there's still almost no managed care, so Blue Cross, as I mentioned,
21 is by far the dominant provider or insurance provider and they're also by far the most dominant of the
22 exchange plan. So that really doesn't look like it's going to change any time soon in our state, so Medicaid
23 does not use Blue Cross. Medicaid is more of an in-house developed network. Many of the providers are
24 common to both. Since Blue Cross has almost all, the providers that are enrolled with Medicaid obviously
25 would be in both, but there are quite a few providers who are not in Medicaid, so, you know, particularly

1 dental, a lot of specialists.

2 And I think that's one thing that has been great about the flexibility allowed states in CHIP is so,
3 you know, the situation in Alabama is different probably than most states, but it gave us the flexibility to set
4 up a program that made sense in our state, but just still very, very little managed care in Alabama.

5 MS. SONOSKY: And I think, as I discussed in the District, we are primarily a managed care state
6 and I think it's been pretty constant that it is also managed care organizations that are primarily serving the
7 Medicaid population. So our Blue Cross, the Kaisers, they are not part of the Medicaid world in the
8 District.

9 And the District, I think, is also unique with its size and with where it is. I tend to think in terms of
10 serving the kids who are in managed care, really 80 percent of those kids are served by Children's National
11 Medical Center, Georgetown, and then we have FQHCs in the city that serve a large number of our
12 children, between Unity and Mary's Center, Children's and Georgetown that's seeing 80 percent of our kids
13 and they're all involved in our managed care organizations.

14 MS. MENDOZA: In Virginia, we've had a long history with managed care. Our managed care
15 programs for Medicaid started in the mid-90s and actually, when we created the Separate program in 2001,
16 our CHIP program was going to be 100 percent managed care. There were some last-minute tweaks and so
17 there is still a short period of fee for service, but every child goes into managed care with very, very few
18 exceptions, so it's almost 100 percent and has been for basically since 2001. Although we weren't statewide
19 at that point, there were a few pockets in the state that didn't have managed care organizations contracted.
20 We have statewide for our program for quite a while for CHIP.

21 Because our Separate CHIP program is also in the same agency as the Medicaid agency, the
22 contracted managed care organizations for CHIP and for Medicaid are the same. We have required them to
23 be NCQA accredited and so there are a number of our commercial plans that also contracted with the state,
24 some of the biggest ones in the state actually. But we do have a couple that are only public coverage MCOs
25 just contracted with us.

1 COMMISSIONER COHEN: And are the ones that do Medicaid and CHIP in your state, are they
2 also, for the most part, in the exchange?
3 MS. MENDOZA: There are some differences but yes, there are some that overlap.
4 COMMISSIONER COHEN: So some of the plans are in the exchange and some are not?
5 MS. MENDOZA: Yes.
6 COMMISSIONER COHEN: And presumably some additional plans are also in the exchange?
7 MS. MENDOZA: Yes.
8 COMMISSIONER COHEN: Okay. Thanks so much.
9 CHAIR ROWLAND: David and then Sara.
10 VICE CHAIR SUNDWALL: Thank you for your presentations. We heard before you were
11 coming about the different kinds of CHIP programs, and this really illustrates for me how different they are.
12 I have a question, Colleen, for you. I'm just astonished at the data you provided. Eighty percent of
13 DC children are on CHP?
14 MS. SONOSKY: Well, are on CHIP and Medicaid, so through the Medicaid program, they're -- and
15 that is the data we reported to CMS on the 416 was about 97,000 children were eligible for EPSDT at some
16 point during the year. That is not the same number as those who were enrolled for 90 days with continuous
17 coverage, but it is still relatively high. So we have been working --
18 VICE CHAIR SUNDWALL: That City's --
19 MS. SONOSKY: -- on our numbers with the data from the total number of children in the District
20 from Census to the numbers that we report to CMS to try to get at -- and it does range at certain points, but
21 it is very high. I mean it's between 70 and 80 percent.
22 VICE CHAIR SUNDWALL: Very good. Wow. My perspective is that, as a clinician and public
23 health doctor, I worked -- just to let you know I'm not uninformed about the District. I worked for 17
24 years as a volunteer physician at one of the Unity clinics, the Federal City Shelter, so I know the kinds of
25 challenges that are faced.

1 However, it begs the question about coverage and outcomes because as you know, most measures
2 that I'm aware of, the District ranks very, very poorly and yet we spend $2.7 billion on just this program. I
3 don't know what that works out to per child, but it's a lot, a lot of money. How well do you or how closely
4 do you work with public health to target your funding to improve those poor health indicators that we
5 measure and compare ourselves with with other areas? Because I just go back to Reed Tuckson, a longtime
6 friend of mine, who -- the challenges he faced when he was Commissioner of Health in the District, and he
7 was troubled by notwithstanding coverage, which had a very low eligibility requirement, they still had these
8 very poor outcomes, so how do you coordinate your spending with public health?
9 MS. SONOSKY: The Department of Health is -- we -- I mean we work with them on a number of
10 the activities that I talked about in terms of the primary care integration with developmental screens and
11 mental health screens. The Department of Health has the Title V agency. I work with them. My division
12 works with them all the time and in my discussions on this, you know, the District is doing very well on the
13 coverage aspect, and where we are trying to focus right now is looking at how well we are doing with
14 utilization. And then I completely agree with you that the next phase that we have to get to is where we are
15 on the quality of those services and then on the outcomes.
16 So I'm still trying to kind of get a grasp of how our kids are being served and what the utilization
17 numbers are, and that is something that we work on with the Department of Health, with the Department
18 of Behavioral Health. There's also many children in the foster care system in the District through our Child
19 Welfare agency. So it's something that is an ongoing challenge but is one of my top priorities.
20 CHAIR ROWLAND: Sara.
21 COMMISSIONER ROSENBAUM: Thank you. This panel was extremely helpful. Clearly, one of
22 the things that we'll be grappling with in our advisory role to Congress is this question Andy touched on,
23 and I want to come back to it, which are some of the questions of alignment across markets.
24 One of the areas that has tended to be the murkiest is this question of coverage design, and I'm
25 thinking now not of Medicaid which has, of course, a very unique coverage design. It's different for

1 children from everything else. But I'm interested in coverage design between the CHIP benefit and the
2 essential health benefit. And I'm interested in four particular types of services, and I wonder if you could
3 just talk about those a little bit.

4 The first one is family planning benefits for adolescents, what the current practice in Alabama and
5 Virginia is.

6 The second is mental health and substance use disorder services and also how you're reacting to the
7 new parity rule.

8 The third is habilitative services and how your programs deal with habilitative services. Those are
9 the three big areas. And as I say, in the case of DC, it would be my understanding that we're looking at
10 whatever the Medicaid benefit design is. So it's particularly Virginia and Alabama that I'm most interested
11 in.

12 MS. CALDWELL: So when Alabama was first discussing putting in place a separate program and
13 particularly a private delivery model, advocates for children with special health care needs approached us
14 very concerned that there would be no EPSDT in our program. And so to address those concerns, we put
15 in a third phase of our CHIP program called "All Kids PLUS." And what that is is really a funding
16 mechanism. We partnered with CRS which is our Title V Children with Special Health Care Needs agency
17 and with the Department of Mental Health. So for All Kids enrollees who were receiving services through
18 mental health, through our community mental health centers and/or through our CRS clinics, if and when
19 these enrollees exceeded the basic benefit limits in our CHIP program, these partner agencies could
20 continue providing services above and behind the basic benefit limit. Those agencies put up the state match
21 and the federal funding was provided. With the rationale as safety net providers, these entities would deliver
22 the services anyway and most likely out of 100 percent state dollars. So they were able to put up the state
23 match and benefit from the CHIP federal dollars.

24 Through our analysis of our CHIP program over the years, we have seen that even though we do
25 not have EPSDT, that parents report that an overwhelming majority of the services needed by their children

1 are covered in the basic benefit package. And so with the plus component, we felt like that added
2 enhancement even on top of that.
3 We are fully compliant with Mental Health Parity which meant the mental health piece of our All
4 Kids PLUS went away. No benefits changed. It's just that agency no longer puts up the state match. We
5 put up the state match on all of those services.
6 And as far as rehabilitative services, now that's probably an area where I may not be as informed as I
7 need to be, but I could also say it's probably an area where there may not be the full array of benefits. But I
8 might say the same thing for Alabama Medicaid. You know, I think that's an area that we look at each other
9 and say, "Hmm, you know, do we fully understand and do we offer the full array?" So --
10 COMMISSIONER ROSENBAUM: I assume by substance use disorders you mean substance
11 abuse services?
12 MS. CALDWELL: No, no. We fully cover those. You question about habilitative services. I'm
13 sorry. So, yes, behavioral health and substance abuse, we're fully compliant. You know, we have a
14 comprehensive benefit package and, you know, like I said --
15 COMMISSIONER ROSENBAUM: Habilitation.
16 MS. CALDWELL: Habilitation, yeah. I mean that's an area that we may be lacking and it may be
17 more out of not fully informed and involved as to the full range of that. I mean even with the essential
18 health benefits, you know, we sat around and discussed exactly what does that mean and where's our
19 benefit, you know, in alignment with that.
20 So as far as the benefits for children, they are in place in our CHIP program even without EPSDT.
21 COMMISSIONER ROSENBAUM: And family planning (inaudible) --
22 MS. CALDWELL: Family planning, absolutely, fully array and we have since day one of the
23 program. So even though we don't technically have EPSDT, the benefits are in place to cover what children
24 need, and in Alabama Medicaid -- and I don't mean this mean against Alabama Medicaid -- I mean they
25 certainly would present the facts the same way -- the network issues are such that in theory, you know,

1 EPSDT provides everything to children, but if the children can't get the services, then that's a moot point.
2 And so in CHIP, yeah, we don't technically have EPSDT, but we do have the benefits and we have the
3 network capacity to deliver it, so.

4 MS. MENDOZA: We also have family planning coverage for teens in our basic benefit package
5 and so that's not an issue. Substance abuse -- because we went with the State Employee Plan as our model
6 plan, we had that really as a covered benefit before Medicaid did. Because Medicaid was paying for it
7 through EPSDT and it wasn't a basic coverage. So we've got that covered.

8 I think with mental health, I think the one thing that we've struggled with, and I think other CHIP
9 programs have struggled with, is the not being able to utilize freestanding psych facilities. And that has
10 been, you know, a significant barrier on benefits and coverage of children over the years. And so that's
11 something, you know, that federal bar would be something that would be good to get rid of.

12 COMMISSIONER ROSENBAUM: And habilitation?

13 MS. MENDOZA: And habilitation. I think we're -- like Cathy, we haven't spent a whole lot of time
14 looking at that. But because we have our programs through -- mainly through the managed care
15 organizations, we look at -- we have language in about medically necessary coverage. And we just haven't
16 had a lot of issues with not having services provided.

17 So I think -- I don't know that there's an issue but we haven't really looked into it substantially.

18 CHAIR ROWLAND: Okay. I have Burt, Robin, Judy and Sharon. Burt?

19 MR. EDELSTEIN: Colleen, you mentioned that a fair amount of your work revolves around
20 integration of behavioral, developmental, dental with health services. So I'm wondering if you could expand
21 on that a little bit and explain any lessons learned or experiences gained that would help others in
22 understanding the full range of EPSDT services.

23 And then, Cathy, you mentioned that your dental network is not nearly as robust. And both
24 Virginia and Alabama have had remarkable improvements in their Medicaid dental programs. So I'm
25 wondering how the CHIP dental programs are functioning relative to the Medicaid programs. Because this

1 is one of those situations where -- one of those less common situations where Medicaid sort of sets the
2 standard.
3 MS. SONOSKY: Sure. I'd mentioned that one of the major pieces that I'm working on is what I
4 call kind of an integration project. And it all has really, I would say congealed at -- to this point, and in
5 preparation for our FY15 budget, to really look at what -- how providers bill well child visits for specific
6 screens in oral health, developmental health and behavioral health, and making recommendations on --
7 especially on the developmental and mental health side on the specific screens as -- and working through
8 our training with providers on what those screens are, what to expect, how to bill for them, and having
9 really clear guidance for them.
10 On the oral health side, we are one of the -- I think one of the last states to implement the fluoride
11 varnish implementation for primary care providers. But that is something that -- part of an overall oral
12 health strategy is looking at, for young children, what a primary care provider needs to know on the oral
13 health side, as well as really doing some work around building up our oral health services for all kids and
14 working with the schools on providing sealants in schools and any other services for targeted programs.
15 MR. EDELSTEIN: Yeah. I believe since '87 the oral health part of EPSDT requires a dental exam
16 by a dentist.
17 MS. SONOSKY: Yes.
18 MR. EDELSTEIN: So there's probably not an oral screening component required on the medical
19 side. But since '87, there's been growing recognition that physicians have an important role in screening. So -
20 MS. SONOSKY: And that's part of -- that's been part of the training that we've been trying to do.
21 And fluoride varnish is one of the ways that we're trying to get at that with the young children, but also have
22 a focus on all children and the importance of primary care providers looking at oral -- the oral health
23 assessments.
24 Both -- under District law there's the school -- there's a school health form that needs to go in every
25 year, plus an oral health form that needs to be submitted. So that is part of how we, you know, try to work

1 with our Department of Health on how best to use those forms and how they -- and how they're
2 implemented and how they can be used.
3 MS. CALDWELL: So when I said 75 percent of the dentists in the state in the Blue Cross network,
4 I actually meant that as in, "Wow." I mean, that's incredible. So the ones that aren't in the Blue Cross
5 network are the ones that are in zero dental networks, just the ones that don't participate in any.
6 So our CHIP dental network is wonderful. Access is great. And we do reimburse off the
7 commercial fee schedule. In Medicaid -- so it is a more limited network but things have improved in
8 Alabama over the last probably decade in Medicaid dental.
9 What happened -- and it's been probably seven or eight years ago now -- Alabama Medicaid raised
10 their dental rates to Blue Cross rates so that was very popular. They've not been increased since then so,
11 you know, they're pretty out of date. And it's still the practice in Alabama Medicaid, like everywhere, I
12 guess, that many not unlimited.
13 We report our data to Insure Kids Now website, you know, the dental directory. There are dentists
14 in Alabama that don't want to be listed because if they're listed, you know, in the Medicaid directory, they
15 have to take them or, you know, they'll feel like they'll be overwhelmed.
16 With CHIP -- so the Blue Cross contract with all providers say you will take everybody from every
17 plan, you know, unless you've quit taking new patients completely. So it's full open access to the entire Blue
18 Cross network for CHIP enrollees. So, yes, the CHIP network is more comprehensive than Medicaid in
19 Alabama even though Medicaid has made improvements over the years.
20 And Colleen mentioned fluoride varnish. Alabama Medicaid has a fluoride varnish program for
21 pediatricians and nurse practitioners on their staff. We've added that benefit in CHIP. It's utilized very,
22 very, very rarely because there is more dental access. But we still think it's a good thing, particularly with
23 siblings. I mean, you know, there's still a situation where there may be a need to have that benefit in CHIP
24 so that's why we put it in place. But it's certainly, I think, more necessary in Medicaid.
25 So did I answer your question?

1 MS. MENDOZA: In Virginia, the dental benefits were in the MCO contracts. But when we
2 redesigned, we put a lot of focus on the dental program a number of years ago. And we carved it out. We
3 got a third-party administrator to, you know, process the claims and everything.
4 And we had a rate increase but we also had dental providers around the table helping us design the
5 program so -- you know, helping us look at each rate and seeing what needed to be, you know, adjusted
6 how. So we had a lot of buy-in. In the simplification of the dentist having one claims process versus, you
7 know, six or seven for our kids was very important.
8 At that time also when we carved it out, we made all the CHIP dental benefits the same as the
9 Medicaid. And so it streamlined it even further, with no copays or anything on the CHIP side for dental
10 services. And so we were actually in a good place when CHIPRA came along in 2009 and said, you know,
11 separate CHIPs or CHIPs -- you have to, you know, meet this level of coverage for your dental programs.
12 We already had orthodontia and everything.
13 So I think just that focus and really having the providers around the table -- and we had some folks
14 in our agency -- our agency director really worked closely with the Dental Association and really make
15 rounds about the importance and, you know, take five -- just take five kids, you know, if you've never taken
16 them before.
17 So over time, just that focus -- that continual focus on oral health has really helped us improve our
18 rates. But we still have a way to go too. We still have room for improvement. Yeah.
19 CHAIR ROWLAND: Robin?
20 COMMISSIONER SMITH: Thank you. My question's a compound question -- I apologize -- but
21 is based on Colleen's information, the Medicaid benefit delivery system. But if any of y'all have anything to
22 add about what your states are providing or any info, I'd love to hear it also.
23 Under the HSCSN Program for the disabled children -- well, my background is in -- I provide foster
24 and we also adopted children -- use Medicaid, who are both healthy and medically complex. So I wanted to

1 know if that program was passive enrollment and how that worked and also who provides the coordination
2 of care for those children. But I'm not done.
3 Also, foster children tend to be constantly transitioning, unfortunately, between family parents,
4 extended family, foster parents, sometimes more than one foster parent, group homes, and then maybe even
5 to adoptive parents or back to family. So I'm wondering if there's been any thought of actually putting them
6 into a coordinated care program so that they don't fall through the cracks and they get the continuity of
7 care, wherever they are.
8 MS. SONOSKY: Well, actually that is something that we are thinking of with HSCSN to become
9 an ASO, an administrative services organization, for the fee-for-service children to provide some care
10 coordination. So that is something that may be happening in the future and we're looking at what those
11 options are and discussing it.
12 And so the foster children are primarily in fee-for-service. They are not within the HSCSN system.
13 And HSCSN is a small, special needs plan. Yes, sorry?
14 COMMISSIONER SMITH: Does that include the medically complex foster children? Would they
15 be in medical --
16 MS. SONOSKY: I'll have to check on that but I do think that they -- it would be -- it would
17 depend. They can opt into HSCSN but I don't -- my understanding is that most of them do not. So that's
18 my overall understanding.
19 COMMISSIONER SMITH: My son was in a highly coordinated, medically fragile care program in
20 Charleston, South Carolina. And it's defunct now, unfortunately, but, you know, it was just so phenomenal.
21 That's where I'm kind of coming from.
22 MS. SONOSKY: Okay. Most of -- we do have a Katie Beckett eligibility pathway. And most of
23 those children are through -- or go through HSCSN and are served by HSCSN. They are connected to the
24 HSC Foundation and have just always had a strong history around medically complex and fragile children
25 and have -- you know, all managed care organizations have some aspect of care coordination, but they have

1 just, you know, I would say, kind of an enhanced way of looking at it -- I don't know if that's with more
2 staff but -- and just have teams and have plans to help children transition out.
3 And so that is primarily the work with HSCSN. And again, in DC, because we are small, it is easier
4 to try to manage that. And on the -- I don't think that there's any difference on the enrollment side. The
5 enrollment of -- you know, if they needed to recertify would be as for any children in the Medicaid Program.
6 And, you know, if they're foster care, they just stay on. So that wouldn't -- but that's for all children
7 -- all foster care kids.
8 CHAIR ROWLAND: Judy?
9 COMMISSIONER MOORE: I'm sorry. Sara was talking about benefits differentiation. And I
10 wanted to follow up that -- those thoughts of differences between Medicaid and CHIP Programs in terms of
11 payment rates. And I think Cathy alluded a little bit to that around the Blue Cross Blue Shield network. I
12 know in a number of states, at least in the past, there have been higher payment rates in CHIP than in
13 Medicaid. And I'm wondering to the extent to which that is a phenomenon and how you address those
14 issues.
15 MS. MENDOZA: In Virginia, if it's a -- if it's something that's carved out of managed care or some
16 -- you know, a period where we're covering them in fee-for-service before they go into managed care, our
17 Medicaid and CHIP rates are exactly the same. In managed care, our PMPM rates are actually lower for
18 CHIP than they are for Medicaid.
19 And then the managed care organizations, of course, contract on an individual basis with providers.
20 And so, you know, it's that provider that they contract with and so it varies. And generally, though, they're
21 going to be paying the provider probably the same rate whether it's a CHIP child or a Medicaid child.
22 MS. CALDWELL: And you're right; I did touch on this. In general, if you put the CHIP fee
23 schedule up to the Medicaid fee schedule, CHIP is probably higher in general. There are certainly some
24 services where Medicaid's higher. As I pointed out, once we got to digging pretty deep, when you look at all
25 the moving parts in Medicaid -- and then there are -- and especially on the inpatient side, there are enhanced

1 payments to hospital. And then there is some shifting of money back to Medicaid for state -- to use as state
2 dollars.
3 And so there's a lot of shifting back and forth. We don't use those complex funding mechanisms in
4 CHIP. So when we said, "Okay, bottom line, what's the rate," it definitely was higher than what we pay.
5 Now, when it's all said and done, whether the hospital gets to keep, you know, higher than what we would
6 have paid, I can't -- I couldn't make sense of it at that level.
7 But in general, I would say CHIP is higher. I do think some of the management components yields
8 a bottom line that I would compare our PMPM to children in Medicaid, you know, any day of the year, if I
9 could actually get comparable numbers. So -- but, yeah, in general, I think providers get paid a little more
10 and certainly with less administrative burden as well.
11 CHAIR ROWLAND: Okay. And Sharon?
12 COMMISSIONER CARTE: Thanks so much, folks. I heard you all speak about things like
13 consumer-centric -- is that the term you used, Rebecca -- approach with CHIP -- the comprehensiveness of
14 the benefits, the outreach efforts that have brought both CHIP and Medicaid coverage to children and the
15 coordination across all children services that has occurred because of CHIP.
16 And I think that that's something -- when I go to our national meetings, I sense that for the separate
17 CHIP directors who've been there, whose tenure goes back past authorization to the earlier days, there's
18 kind of a fierce pride there for the things that CHIP did to elevate things for all children and not just in the
19 arena of coverage.
20 But as we look out into the more distant future for CHIP, I see that these CHIP directors somewhat
21 sit on the horns of a dilemma about, as you look at the possibility that the CHIP kids, after the stairstep
22 transition, will potentially be folded into Medicaid or potentially be in the Exchange. And I'd like for you to
23 reflect on what that might seem to you, both the positives of either of those or the concerns that come with
24 either of those in the broad sense.

1 MS. MENDOZA: I guess my concerns with the children potentially moving to the Exchange, as
2 we're doing with our pregnant women in January, is we really don't know how things are working. And my
3 fear is that there isn't the focus on children's health in the Exchange. You know, it's everyone getting
4 coverage and not children and their special healthcare needs and that -- so they'll get lost in the mix.
5 I mean, even this week, I believe, there was an article about the dental coverage issue with the
6 Exchange for children and that, you know, plans don't have to offer it. It can be separate. But then the
7 premium subsidy doesn't cover that separate plan. And so there's a fear again -- we're going back -- and that
8 the children will not get, you know, essential oral health coverage that they need. And so that's just an
9 example of things that I'm afraid of.
10 Also, just the cost of coverage, you know, how things shake out with families and the family glitch
11 issue, I think, is worrisome because it hasn't been fixed yet. So we still have that issue where someone's
12 offered it at work -- family coverage at work, but there's no -- you know, the employer only covers, you
13 know, cost for the employee and not the dependants.
14 And so because it's offered, they're not eligible for premium subsidy to buy, you know, Exchange
15 coverage. So they would have to pay the full price -- the full cost. And so, you know, I think we've got
16 some holes yet that need to be filled before Exchange coverage would be a very robust, viable option
17 compared to option to what we have now.
18 And on the flip side, the Medicaid, I just have a hard time seeing in a state like Virginia, which is
19 fairly fiscally conservative, expanding Medicaid for these kids for fear -- you know, it's the same kind of
20 debate as the expansion for adults, you know, and Medicaid. It's, you know, the fear that, are we going to
21 be able to support this additional population and the match rate and the additional benefits?
22 Like, our separate CHIP program doesn't cover non-emergency transportation, for example. You
23 know, so those -- the extra costs to the state that it's -- you know, it's a benefit -- an entitlement benefit
24 versus block grant that we have more flexibility. And so all those issues, I think, would play into, you know,
25 maybe folks in Virginia not looking as positively about a Medicaid expansion for CHIP-covered kids.

1 MS. SONOSKY: From the District perspective, I agree with Rebecca. For us, I think my
2 presentation showed that it would be pretty seamless and that it would be something that would be very
3 doable. But the dilemma comes down to the percentage of children in the CHIP Medicaid expansion
4 categories and how much that -- and how much we really have to move with that and moving states into
5 making those hard decisions, which goes back to the history of why CHIP was enacted in the first place to
6 be something that in a sense was not Medicaid or something different from Medicaid.
7 So -- and then I think on the -- so you have the dilemma on how much can we move children from
8 CHIP into Medicaid. And I think the same points that Rebecca was making about the lack of focus of
9 children in the Exchanges is something that is -- would be -- is worrisome.
10 MS. CALDWELL: So philosophically, you know, I think it sounds great. You know, you have
11 Medicaid for low income people and one plan for families above the Medicaid limit. I don't think that
12 system is in place. I mean, so theoretically, it's -- yeah, it sounds great, but right now, I don't think that
13 there's such a system in place.
14 So even if a few years from now we look at Exchange plans and have a discussion around, do they
15 have everything they need to have for children, I think that would be a great discussion. But doing away
16 with a CHIP program before we have evidence that those type things are in place, I think would be, you
17 know, really, really bad for a lot of children.
18 I also think that many children would become uninsured. I mean, I think many of the factors -- as
19 Colleen and Rebecca have pointed out, many of the factors that contributed to so many uninsured children
20 prior to CHIP, they're still going to be in place. There are still going to be families that can't afford that
21 employer insurance.
22 There are going to be families that can't employ -- you know, afford the premium subsidized
23 Exchange plans. And then for -- even for families that do have those plans, the copayments -- you know,
24 the cost-sharing is going to be prohibitive. So it's almost like we're comparing what we have now to a
25 theoretical world.

1 And I think there would be complications even if we had a real world to compare to and we don't
2 even have that. So I think that it would be very, very premature to just assume that the children in CHIP
3 are going to find their way either to an Exchange plan or to Medicaid. And without the enhanced funding,
4 I'm certain that Alabama wouldn't be able to expand Medicaid and, you know, like I said, some of the issues
5 I think with the Exchange plan. So -- yeah.
6 CHAIR ROWLAND: On that note, I would like to thank you for sharing both your experiences. I
7 think we also really have gotten a real sense of the diversity of the CHIP programs from your three different
8 models. And I think as we go forward, obviously, thinking about the changes with regard to each of the
9 models is important too.
10 We don't have -- you know, we always talk about having 50 Medicaid programs. Well, we have lots
11 of different CHIP programs too and we need to think that through as we look at some of the strategies
12 going forward. You've given us a lot of food for thought. And I thank you for coming to this meeting
13 when we had intended to have you at our October meeting but could not have a meeting while the
14 government was shut down.
15 So thank you for your flexibility, which is, I guess, part of the CHIP strategy for being able to come
16 today and for sharing your thoughts with us. So thank you very much.
17 And since we're running slightly over, I'm going to cancel the break and call the second panel to
18 come to the table now. Thank you.
19 (Brief pause.)
20 CHAIR ROWLAND: Thank you very much. I want to welcome Joan Henneberry and Tricia
21 Brooks to continue our discussion of CHIP. We've gone from current CHIP directors to former CHIP
22 directors with an incredible amount of experience in both looking at the program, working with the
23 Medicaid side in the states, as well as with the CHIP program, and now being analysts and individuals who
24 can give us some reflections on both their experience with CHIP and their insights to the struggle going

1 forward of how we either develop the CHIP program or move it more toward the Exchange and Medicaid
2 model.
3 I think you've had a good panel to set you up. So I welcome Joan Henneberry, a principal with
4 Health Management Associates, but also someone with experience first with the NGA, when she was here,
5 and then later with the State of Colorado, and Tricia Brooks, the senior fellow at the Center for Children
6 and Families at Georgetown University's Health Policy Institute, with a lot of experience as the CHIP
7 director in New Hampshire and a lot of experience now analyzing coverage and coverage options for
8 children.
9 So welcome to both of you and we look forward to your views and your insights into the future of
10 CHIP. Thank you. Joan, I guess you'll go first.
11 **### SESSION 2: THE FUTURE OF CHIP: PART II**
12 * MS. HENNEBERRY: Thank you very much. Good morning, everyone. I'd like to just
13 share a little bit of information about some work that we're doing in Colorado to this very question that
14 you've been discussing this morning. We are finishing up a paper that we did for the Colorado Children's
15 Campaign and the All Kids Covered Coalition that really brings attention to this question of the future of
16 children's health -- public children's health insurance coverage.
17 And I will say some of the reason the advocacy organizations asked us to do this work is there is no
18 current organized policy discussion or strategy going on, at least in our state, to answer this question about
19 what happens post-2015 and post-2019. And we do have -- we did have a standalone CHIP program for --
20 up until last year, when we did the early expansion.
21 And so technically, CMS considers Colorado a mixed state now, if you will. But really, we've been
22 operating and even had a state-only children's health insurance program even pre-CHIP. So I'm just going
23 to give you the big categories since we're going to try and keep our opening remarks to about ten minutes --
24 the big categories and questions that we are recommending the state look at. And then if you have

1 questions about what's underneath that and some of the detail that we're raising in the paper that we're
2 doing, I'll be happy to answer those.
3 Some of this you heard from the first panel. And our research involved looking at the history of the
4 state program, the federal program, what was behind the policy decision in Colorado, what was going on
5 politically and in the Marketplace at the time, what was behind the decision to create a standalone program
6 instead of expanding Medicaid. And I can answer those questions later on if you're interested.
7 So really the big take-away from the work we're doing right now is, if you wanted to ask the
8 question, is it a good idea or a bad idea in Colorado or perhaps any other state to let the CHIP program fade
9 away and blend into these newly created opportunities in Marketplaces -- and Colorado is expanding
10 Medicaid; we did build our own exchange. We've pretty much embraced every single policy option there is
11 to embrace and every grant opportunity there is to go after in the Affordable Care Act. So we are all in.
12 But if you ask this question, is it a good idea or a bad idea, I think our answer would be, we don't
13 know. We don't know. And we will not know -- and we certainly will not know unless we put those
14 research questions on the table today and monitor that and plan for that transition.
15 And my fear is that it's going to happen accidentally, that it won't be a deliberate, thoughtful, value-
16 based policy decision, that it will just happen because, you know, at the right day and the right legislative
17 session somebody will raise their hand and say, "Why do we need this program anymore?" And they'll take
18 a vote and it'll seem logical at the time. And no one will have done any of that work. And that's really my
19 biggest fear.
20 So you heard the earlier panel talk about some of the issues and these are ones we are raising in this
21 paper as well. This attention to children's coverage -- and I don't think this really should be underestimated
22 how important this is, that -- not just what it did for standalone CHIP programs and for children's health in
23 general, but you heard the state say the values and the flexibility and the other benefits that states were
24 allowed under CHIP through federal and state authority that brought improvements to the Medicaid
25 program really cannot be understated, in my opinion.

1 You know, just go back to what happened in '97, '98, '99, when we started -- you're seeing some of
2 this today with marketing and outreach for the Exchanges. And look at what's happening. We're finding all
3 sorts of people who are Medicaid eligible. Same thing happened in -- when we rolled out the CHIP
4 program.
5 For every -- in any given state for every child we found who was eligible for CHIP, we found two,
6 three, four, five Medicaid-eligible kids. And it's not -- we just had not -- typically most states had not done
7 that kind of marketing and targeted outreach to Medicaid families for their kids until the CHIP program
8 came along. Some had, certainly.
9 But it also gave us the opportunity to develop a very -- fairly robust research agenda about children's
10 health. So we all know now that you have to start with some education with families. And then you have to
11 do some outreach. And then you have to do enrollment. And then you have to find access. And then you
12 actually have to provide some services. And then you have to figure out which are the right services that
13 actually make kids healthier. And then you have to begin to look at that longitudinally and see what
14 difference it makes.
15 And one of the things we're very interested in doing in Colorado, because we have been covering
16 kids and raised eligibility and doing all this work, now we're very interested in linking all of this to other
17 things that matter for children, like when you do all of those things that you're supposed to do -- and
18 especially if you do them before preschool age, do you actually -- we say this all the time, if kids get coverage
19 and access of services, they're healthier, ready for school, they learn better, they do better, yada, yada.
20 But we don't really know that. I mean, very few studies have been done to prove, though, all of
21 those linkages and those circular relationships. But the -- having a standalone program and having access to
22 that has really enabled us, I think, to build a more robust research agenda.
23 So this attention to kids' coverage, I think, is really important. People are very worried because the
24 Exchanges and even the Medicaid expansion is really more about adults because we have done all this great

1 work with kids. So people are worried that kids will lose attention and we'll lose some of those

2 opportunities for research.

3 The complexity of coverage for families -- you've heard the -- you know, churn, movement back and

4 forth, blended families. We're very worried about that. And having -- it actually in some ways makes the

5 case for fewer programs. Part of our study in looking at the history and some research -- we did a number

6 of stakeholder interviews.

7 And in some ways it would have been much, much easier to do a Medicaid expansion back in '97

8 and '98 instead of create another new program. In fact, some of the -- how many years later is this? Some

9 of the administrative challenges and operational issues that we continue to have today in 2013, almost 2014,

10 related to systems and eligibility and all these, you know, lost cases and spans and all this craziness in -- with

11 the technology, those all stem from that first policy decision to create a separate program.

12 So in some ways it would have been much easier, but we didn't go down that road. But I think all

13 this complexity for families is really important. But I have always had a bias that it would be much easier for

14 families for everybody to be in the same health plan and have access to the same network.

15 But I'm challenged when I say that sometimes by people who know more about this than me. And

16 I'm challenged sometimes when parents say to me, "Well, you know, yes, it's nice, but I always take my kids

17 to the pediatrician anyway. It's not like I ever take my kids to the same doctor that I go to."

18 So I just think it's a question that we've made assumptions about and we're not sure what the real

19 answer is for families. So I think that's important. Affordability -- you heard the state folks. You know, we

20 have no idea. When -- and Sara, correct me if I'm wrong, but, you know -- or Judy would know this too.

21 So the 5 percent cap for out-of-pocket expenses for families in the CHIP program, we sort of made that up.

22 I mean, nobody knew the right number. You know, we didn't know. We didn't have any experience to base

23 that on. It kind of sounded good and we used it and it seems to work. But we have no idea whether the

24 differences between what CHIP families spend now and what those families might spend if their children

1 are moved to an Exchange plan -- we don't know what those differences are going to be and we don't know
2 how many families will be impacted by a new affordability standard. And that's a huge, huge question.
3 The benefits, we -- again, we haven't quite seen -- I think there is some work going on at the
4 national level -- I think maybe NASHP -- I'm not sure who's doing that -- but to do a crosswalk for us
5 about, you know, what the typical essential benefits and required benefits in a typical standalone
6 CHIP plan are as compared to the essential benefits that are required in the state QHPs.
7 And we think every state should do that own -- you know, should do a really pretty deep dive into
8 that to make sure. One of the most amazing quotes we heard -- this was from a parent in our stakeholder
9 interviews -- was, you know, "Having a healthy kid isn't just about having the medical care." And this is one
10 of the things I think people are concerned about, that even though our CHIP kids have been in commercial
11 plans from Day 1 -- they've all been in managed care plans and they've done very well in that -- but we're
12 not sure that all of the plans -- there are only three plans and one ASO plan in Colorado.
13 So that gives you -- you have a lot more intimate relationship when you only have that number of
14 health plans and you can work with them and they're on advisory committees. And they've helped us make
15 it a good program over the years.
16 So now, if all these -- were most of these kids moved to the Exchange and their parents start buying
17 plans in the Exchange, you have a bigger universe to deal with. You have different sets of products. We
18 don't know whether -- and people suspect that all of those companies and all of those types of products are
19 not going to be as used to serving families in this middle income category -- lower middle income category
20 and families whose lives oftentimes are far more complex than what the plans are used to providing or that
21 providers in their networks are used to providing.
22 There are issues that need to come up, social supports and parenting and all kinds of other things
23 that a standalone plan or a plan that you -- a governmental entity purchases on behalf of a certain
24 population, we know what to contract for. We know the wraparound services that we need and expect for
25 those families. And people are a little nervous that a typical commercial plan isn't going to know that.

1 And then in our state, 16 percent of the uninsured children in Colorado are undocumented. So we
2 all know that they are not going to be eligible for anything. And it is of big concern about who owns then
3 the ongoing care and needs and services and making sure that those children continue to get direct
4 healthcare services.
5 It's not that we don't have those provider networks and safety nets to serve those kids. We do. But
6 we're very worried about that and worried about the -- kind of the long-term financial implications, the
7 access issues. Those systems are highly burdened right now with numbers of enrollees and we're very
8 worried about undocumented kids going forward.
9 So our recommendation really is that -- this is an interesting question. We're not assuming that it
10 would be good or bad for children to move from commercial coverage in health plans in CHIP to health
11 plans -- in fact, some of the same health plans sold through the Exchange and being in the same plan with
12 their parents. For some families that could be actually very, very helpful and very convenient.
13 But we do think there are a number of research questions that are important to look at. We think it
14 should be a thoughtful policy discussion. There's time to have a thoughtful policy discussion. And we
15 would hope that policymakers and legislators would take advantage of that and not wait until it's a crisis.
16 * MS. BROOKS: Well, hello, everyone. Thank you so much for the opportunity to come
17 share my thoughts with you. You're going to hear me echo a lot of what you've heard this morning. But
18 one thing we learned about doing outreach for children's coverage is that you have to get that message and
19 repeat it over and over and over again before it finally sinks in and people take action. But I also want to
20 offer some very specific strategies that we have to strengthen children's coverage today.
21 So it's interesting where we are with health reform because in 1997 CHIP emerged out of the ashes
22 of our last attempt as a country to reform the health system. And at that time, there were 5 million
23 uninsured children who were eligible but not enrolled in Medicaid. And despite previous eligibility
24 expansions over the decade before CHIP came along, it was really evident that effective outreach and
25 simplified procedures were requisites if we were going to make more gains in covering kids. So CHIP's

1 enactment fueled a new determination in our country to enroll eligible children by putting out a welcome
2 mat and by removing red tape. We all know the basics. CHIP incentivized the states to expand coverage
3 with that higher match and with more flexibility. But its impact -- and you've heard this today -- was so
4 much broader than creating a new option for more moderate-income children who were persistently losing
5 private insurance.

6 CHIP's high profile and bipartisan popularity brought about a real appraisal of our approach to
7 children's coverage in the country. And it spurred the states to band -- to, excuse me, brand their programs,
8 to conduct marketing and outreach, to build community partnerships, to test those procedural
9 simplifications that, as I think Rebecca pointed out, both improve administrative efficiency as well as
10 boosting enrollment and retention.

11 But most importantly, CHIP was required to coordinate with Medicaid. And that resulted in a very
12 decisive welcome mat effect on enrollment. Our success in covering kids really has inspired what we see
13 today in the vision for streamlined, coordinated enrollment system with the Marketplaces across that
14 continuum of coverage.

15 Reflecting back as a former CHIP director -- and I'm not going to talk much in my prepared
16 remarks about New Hampshire, but I'm happy to answer questions there because it was even a different
17 model. It was a privately -- it was a legislatively created non-profit that ran the CHIP program in New
18 Hampshire, as is done in Florida.

19 But I believe that the core of CHIP's success was its dedicated focus on children, while Medicaid's
20 attention is dispersed among different groups, many that have more complex needs and higher costs. So
21 CHIP enabled us to lean in and really look at what we were doing with kids' coverage.

22 Notably, CHIP's formative years provided a really ripe pro-child coverage environment for
23 government and state health policy experts and advocates to collaborate on addressing the barriers that
24 inhibited enrollment and retention. Initiatives such as the Covering Kids & Families and the emergence of

1 state-based healthcare conversion foundations helped to build advocacy capacity and policy expertise in the
2 community among stakeholders as they partnered with the states.
3 So at Sweet 16, with the exception of enrollment freezes that were triggered by limited block grant
4 funding in CHIP that briefly marred its success, CHIP really has been that catalyst for advancing coverage,
5 but only in tandem with Medicaid. CHIP has not done it alone.
6 Our country has achieved historic low rates of uninsured children, with low-income children
7 realizing the largest gains. There's ample evidence that children covered by CHIP, like their peers in
8 Medicaid, have better access to care and less unmet need that uninsured children. Parents are very satisfied
9 with the coverage they get through both Medicaid and CHIP and actually feel it is more secure than do
10 parents whose children are insured privately.
11 So there's no question that Medicaid and CHIP have been great successes. The larger question is,
12 on this eve of health reform with Marketplaces in their infancy and a historic transformation of Medicaid
13 and CHIP underway, where do we go from here? So the ACA clearly anticipated the continuation of CHIP
14 with the maintenance of effort provision for children through 2019 and also by bumping up the CHIP
15 match in 2016. But the lack of funding beyond 2015 is very worrisome.
16 Taking an incremental or wait-and-see approach by extending CHIP funding a year at a time will
17 detract from the thoughtful reflection and planning that our nation needs to engage in that Joan talked
18 about. The uncertainty of short-term funding could really stunt the investment of time and resources in
19 continuing to improve children's coverage and evaluate the adequacy of the Marketplace.
20 So to safeguard our progress and ensure children's coverage remains that priority, we believe that
21 funding should be extended for CHIP for the foreseeable future. And there are many reasons why but I'm
22 going to focus on three. At the top of my list are the child-specific issues in ACA implementation that
23 demand attention. You've heard about those today.
24 We must fix the family glitch by appropriately basing the access to affordable employer insurance on
25 the cost of full family, not individual coverage. And though the essential health benefits explicitly include

1 pediatric services the way that dental benefits are being offered in the Marketplace complicated by
2 standalone dental plans is not going to work well. Likewise, it remains to be seen whether the state-defined
3 habilitative services will be sufficient, particularly for children with special healthcare needs.
4 Secondly, the Marketplaces need to mature before we can assess how well they are functioning for
5 children. It took many years to align and streamline CHIP with Medicaid and, likewise, robust
6 implementation of the ACA and evaluation of it will be a multi-year effort.
7 And third, our friends in the state and federal government are stretched beyond capacity. Major IT
8 system overhauls, eligibility in enrollment transformation, delivery system and payment reforms have really
9 maxed out our human capital that's already been depleted by state -- with tight budgets both at the state and
10 federal level and plentiful opportunities outside of state government. So now is probably not the best time
11 to mess with success.
12 As the role of CHIP evolves and broader reforms take hold, we need to keep the spotlight on
13 children. In the coming year, an estimated 28 percent of the children currently enrolled in separate CHIP
14 programs -- over half a million kids -- will be moving in 17 states to Medicaid, eliminating that stairstep
15 eligibility.
16 Consolidation of CHIP and Medicaid eligibility systems is occurring in a dozen states. And yet, on
17 the other hand, there's this new relationship with the Marketplace where coordination with parent coverage
18 is really critical. But some states, like Arkansas -- sorry -- are even contemplating putting their CHIP kids in
19 the Marketplace.
20 So amidst these changes, there really are some key steps that we can take to maintain and advance
21 coverage for kids and I'm going to mention five of them.
22 Number one, cover parents. When parents are covered, families are healthier and more
23 economically secure and their children are more likely to enroll, retain coverage and access needed
24 healthcare services. Expanding Medicaid to parents is vital to covering kids, as demonstrated in

1 Massachusetts, when the parent expansion under health reform nudged the child uninsured rate below 2
2 percent.
3 But boosting Medicaid participation in non-expansion states is equally important and an important
4 strategy because nationwide 46.5 percent of uninsured parents are with incomes below 138 percent FPL
5 currently eligible but not enrolled in Medicaid. So that will help.
6 Number two, promote continuous coverage. Gaps in coverage can be harmful to children's
7 development, particularly at the youngest ages, and it is difficult to adequately measure healthcare quality
8 and outcomes without continuous coverage. Providing 24 or more, rather than 12 months, of continuous
9 eligibility and, even better, considering covering newborns in their first five years of life are ideas that are
10 really worth taking a hard look at.
11 Number three, eliminating CHIP waiting periods. And you've heard this before this morning. In a
12 coverage system intended to create universal access, CHIP waiting periods and, for that matter, limited open
13 enrollment periods or lockout periods make no sense and, moreover, are guaranteed to create administrative
14 bottlenecks and coordination challenges in the federal Marketplace states. When you think about half of the
15 states are already moving in that direction, but we still have -- and half of the 38 that have current waiting
16 periods.
17 Number four, invest in community engagement. The enthusiasm of state and national leaders can
18 certainly hurt or help children's coverage but a solid community of child health champions from providers,
19 policy experts and advocates to outreach partners and enrollment assisters is also vital.
20 Now, I realize this point may be a bit -- or at least seem a bit out of the purview of this commission
21 but it's critical for policy and administrative efforts to recognize and support this community, as has been
22 done by making outreach grants available to community-based organizations, hosting national children's
23 health coverage summits, promoting transparency and a collaborative approach to decision-making and
24 problem-solving that involves community stakeholders.

1 And number five, using data and incentives to drive program improvement and quality. So the
2 initial phase of Medicaid and CHIP performance indicators that were released by CMS this year are a good
3 start but additional metrics and segregation by demographics including age are needed to better pinpoint
4 what our issues and barriers are.
5 And while progress is being made on the quality reporting front, the median number of children's
6 health quality measures last reported by the states is 12 out of the core set of 24. Now, we believe that the
7 CHIPRA performance bonus program could serve as a model to accelerate both the recording of data and
8 the implementation of program improvement strategies going forward.
9 So in closing, our nation's children deserve no less than a thoughtful process to assure they have a
10 sustainable, continuous path to coverage. Poll after poll shows that Americans overwhelmingly believe
11 children should receive the healthcare they need to maximize their potential in life. We have achieved a 99
12 percent coverage rate for our nation's seniors and we should do no less for our kids who trail behind at a 92
13 percent coverage rate.
14 CHIP has proven that our nation's leaders can find bipartisan support in making the coverage a
15 priority but there's definitely work to be done. Smoothing out the rough edges of reform and coordination
16 with the Marketplace are really important. But without CHIP, we could actually lose ground by eclipsing
17 that spotlight that it focuses uniquely on the needs of kids.
18 Our longer-term challenge, I believe, is to take the best of Medicaid, its comprehensive benefits,
19 affordability protections, and guarantee of coverage; and the best of CHIP, its focus on outreach, program
20 simplifications and its bipartisan appeal, to ensure that every child has access to continuous, sustainable
21 coverage from birth to adulthood regardless of their coverage source. Thank you.
22 CHAIR ROWLAND: Thank you all very much. And I saw Sara's hand go up immediately and then
23 Donna after.
24 COMMISSIONER ROSENBAUM: So thank you. I mean, that was really very helpful. So I have
25 a question going to Joan's observations, which I thought were really important -- and Tricia, you echoed

1 some of them and sort of the same theme -- and that is that, given the uncertainty about what's happening
2 out there, whether that alone is -- sort of tips the balance in favor of continuing for some period of time,
3 whatever that period might be -- and I guess my question is, given the uncertainty and given the
4 extraordinarily local nature of health reform, whether the extension should be paired with a lifting of the
5 maintenance of effort requirement so that states can figure this out.
6 If the coverage is extended, but the maintenance of effort provision goes on to 2019, then
7 obviously, Congress has made a choice, the president's made a choice in signing such a law that we will
8 continue a separate program. And I think for the reasons that Joan flagged, and actually for some of the
9 reasons that Tricia flagged, the question is whether we want to continue in that posture because I share --
10 and I particularly share Tricia's concerns that there are all these handles and signals in the Marketplace
11 coverage reforms that Congress wanted the Marketplace to develop pediatric competency. There was a
12 pediatric benefit class that HHS did nothing with, that states are basically doing nothing with.
13 There is, of course, the problem of the affordability issue, which I'm going to park to one side. But
14 given the fact that signals were planted all over the place in the Marketplace reforms and remain there today,
15 should we be thinking along the lines of continuing, but allowing the flexibility to come to the point that
16 states want to come to, particularly because there is a state contribution requirement to continuing with
17 CHIP?
18 And I -- you know, one sort of doesn't know how long we want to keep making the choice to
19 continue a separate program. So I would just be interested in your reactions to this question about the
20 MOE.
21 MS. BROOKS: I'd rather answer the question a year from now. I think it would be easier to see
22 that far in the future. So the MOE, I think, is very largely responsible for that declining number of
23 uninsured children that we saw even through one of the toughest recessions this country has ever
24 experienced. And I understand what you're saying about the CHIP match but, you know, we're -- there's

1 not a lot of talk about this bump-up. And if the bump-up occurs, then I don't see any reason why we
2 wouldn't want to have states continue to have their CHIP programs.
3 You know, the ACA provides for the innovation waivers starting in 2017. It seems to me that there
4 was, you know, this sense that we need to let the dust settle for a couple of years on an initial rollout before
5 we start, you know, testing lots of different things.
6 And so I -- you know, looking at it today with what we can see, what's going on in the initial launch
7 and the -- you know, even though it's going much better in some states, you know, there's a lot of work to
8 be done to get things rolling smoothly. And I would fear for children's coverage if we were to lift the
9 maintenance of effort.
10 MS. HENNEBERRY: Yeah. My response is making any big decision like that that would go into
11 effect in 2015 is way too early. We aren't going to -- if you think about -- so we were in an open enrollment
12 for 2014 coverage. We have to get through at least one, if not two more, of those cycles to really
13 understand the impact that this -- what I call this new state of positive chaos that we're all in -- until we
14 really understand how that's going to settle out, including how it's going to settle out for working families
15 who are coming to the SHOPs with their children because of where they work and what that's going to
16 mean for those kids and what it's going to mean for the movement and the churn and how states are
17 attempting to deal with that.
18 Remember, this isn't -- this is also happening in the same context of states engaged in massive
19 service delivery redesign, payment reforms. I mean, there's just all sorts of things going on at the same time
20 that I think are fascinating and great that they're being done. But we're years away to really understanding
21 how that plays out and how it's going to impact kids.
22 So I don't -- I think it would be, frankly, very foolish to just have it fall off a cliff in 2015. Now, to --
23 COMMISSIONER ROSENBAUM: (Inaudible) --
24 MS. HENNEBERRY: No. The --
25 COMMISSIONER ROSENBAUM: The funding?

1 MS. HENNEBERRY: -- funding.

2 COMMISSIONER ROSENBAUM: Yeah.

3 MS. HENNEBERRY: Now, to your other question though, I do think -- so if I were still in state
4 government, I would be thinking even bigger. I would be looking at 2017 and a waiver opportunity. And
5 Colorado has done this a couple -- a couple of times we have looked at, does it make sense to continue to
6 have separate programs? What if we just had one big kids' program and try to make that more seamless for
7 families and more blended?

8 And we never could get there for lots of reasons. But between that waiver option and between
9 continuous eligibility and the interest that people are having now about, okay, what if we're in this perfect
10 world? Kids are getting great care, great access and the outcomes look good. Then what?

11 What -- how else do we want to link their access to healthcare to other things like early childhood
12 development and school readiness? So people are even talking about bigger connections now. And I just
13 say that because you could link the -- maybe you could. I don't know what you can do in this town
14 anymore. But could you link a phasing out of the maintenance of effort with other policy options that
15 states wanted to experiment with and provide those -- and leave the incentives in place for more innovation
16 without just everything falling off a cliff?

17 CHAIR ROWLAND: Okay. I have Donna but David, are you -- you've got the mic on it then
18 Donna.

19 VICE CHAIR SUNDWALL: I have the mic on it so I get to go first.

20 COMMISSIONER CHECKETT: Even though I raised my hand first?

21 CHAIR ROWLAND: Yes, that's what I just said. He's preempted you here.

22 VICE CHAIR SUNDWALL: I'll be brief. Thank you very much. This is really interesting to me.
23 Because, I think, Joan, you really had -- your observations are spot on. This whole idea that we have,
24 traditionally, had this, kind of articles of faith we go by, that these things are all wonderful and necessary and
25 essential. But you demonstrated to me a sense of humility that we don't know. We really don't know. And

1 this is an opportunity at this transition time where we do better assessment of what would make children
2 healthier. And I think we really do need to be cautious in assuming that all the things we've done, that have
3 been covered, are essential and should continue to be.
4 Just along these lines, I know I'm not supposed to be doing my iPhone. But I looked at an article
5 that just came across from the Mayo Clinic. It's really kind of startling. It's an expansion of what the
6 RAND Corporation did. But this one reviewed 10 years of articles, thousands of articles. Essentially saying
7 that 40 percent of what we do in clinical care isn't of value. And I think that applies to Medicaid coverage
8 and policies as well.
9 So this transition into private coverage or some new version for children being covered. I think, can
10 be very exciting if we take advantage of analyzing it, and monitoring it, like you recommend. And not
11 assume that we should just by darn hold our ground, require maintenance of effort. And make sure we do
12 what we've done in the past.
13 I think we need to be open-minded and see how this unfolds. And I think you're right, that it's
14 going to take a year or two before we know. But if we are acknowledged, the need to really monitor what's
15 happening, which I think the commission can be a valuable resource there. That's a very good suggestion.
16 MS. HENNEBERRY: If I could react to that. I think the example you gave, if I understand some
17 of those studies about how much waste there is in clinical care, I don't believe those are with kids. So it's,
18 sort of, a perfect example of, we may have some very good data about adults. And then we can take action
19 on that in our benefit design and our service delivery models and our payment reform. But I'm not sure we
20 have those same sorts of studies or data about is there waste in the way we deliver and what we deliver to
21 kids? And if there is, where is it?
22 Or are we under serving kids in some area? We -- I think we all knew we were under serving kids in
23 behavioral health, for sure. There's plenty of evidence about that. So it's just another question about we --
24 half of the kids in the Medicaid -- half of the people in Medicaid in Colorado are children. And we don't do
25 nearly as much research about them as we do the adults.

1 MS. BROOKS: And that's because they don't cost very much. And so when they're doing the
2 research, they're looking at ways to save a lot of money. But I do think there's, you know, some evidence
3 that we don't do as good a job. Although, it's been improving of providing those social supports to families,
4 low-income families, particularly families with special needs. You know, as broadly as we might, to make
5 their care as effective as possible.
6 And, you know, there's more innovation certainly going on in that area. But, I don't think the
7 maintenance of effort really; it doesn't impact benefits per se. And yet, you know, there are certainly other
8 protections around what we have to provide for benefits but I agree with Joan.
9 And in New Hampshire we had an all-payers claim database that we could actually compare the
10 experience in healthcare utilization of our kids and CHIP, Medicaid, and in private insurance, as well. So
11 that is an interesting thing that we should be taking a look at.
12 Because for us, you know, when we think about children's health and children's coverage, it's not
13 just about how Medicaid and CHIP deliver that. It's about how they broadly get that, you know, through
14 private insurance as well. The other thing we don't really know a lot about is the extent to which managed
15 care has a real impact or saves money. And I think we need to do more work in looking at that.
16 CHAIR ROWLAND: And when you did that comparison across payer groups, what did you find?
17 MS. BROOKS: So what we found was that CHIP was just almost identical to private insurance.
18 And that Medicaid had some higher use of in-patient services as well as emergency services and slightly
19 reduced preventative care but not much.
20 I think the bigger issue, no surprise to Burt, that the dental, you know, lagged behind. But even
21 privately insured children are not getting dental care up to, you know, 90, 100 percent. I mean, it's -- you
22 know, their -- Medicaid may be at 45 or 50. But, you know, private insurance is, like -- I don't know what
23 the numbers are. Burt, you can correct me but 60 or 65. So, there's work to be done on that front across
24 the board.
25 CHAIR ROWLAND: Burt reminds us of that all the time.

1 MS. BROOKS: I'm sure he does.

2 CHAIR ROWLAND: Donna?

3 COMMISSIONER CHECKETT: Well, thank you so much. I really enjoyed both of your
4 presentations and very thoughtful and also detailed.

5 What do we know about why people drop CHIP coverage? And in particular, I'm wondering about
6 if there's anything in particularly we know about premium and co-pay being reasons behind a family not
7 continuing. Thank you.

8 MS. BROOKS: So, in New Hampshire we had, you know, certainly at the time some of the most
9 robust premiums in the country. Although, our program went to 300 percent of poverty, premiums started
10 at 185 percent of poverty. And we worked really hard with families. I actually have a paper coming out
11 soon on premium administration. Because I think that there are two aspects of people falling off due to
12 premiums.

13 One is affordability. The other is administering them in a way that isn't family friendly or certainly
14 family friendly to low-income families who are on the edge all the time, you know, of putting food on the
15 table or paying the electric bill.

16 So we had a fairly low incidence of disenrollment for non-payment but we also had a premium
17 rescue fund. So that when we encountered families that, you know, had a financial crisis, we could forgive
18 their payment for a couple of months. You know, you work really hard at figuring out whether the family
19 has had a change that's permanent, that would require them to be reevaluated for either a lower premium or
20 a lower -- or no cost coverage or whether it was a temporary loss. You know, the car engine blew up and I
21 had a $700 bill and I can't get to work if I don't fix the car.

22 So, I think, you know, some of those kind of efforts can actually improve our records. You find
23 that when families move from Medicaid to CHIP, that's where your bigger problems are. Is that, you know,
24 picking up that $30 per child, for two children, is just not something that these families who got a 10 cent
25 raise, you know, to equal $40 a -- well, not even $40. Four dollars a week, is not enough to help them cover

1 the premiums. So, you know, that's a particular problem, I think when we're looking at that. But, you
2 know, there's clear evidence that affordability is a problem.
3 The other issue with affordability is that we base everything on the federal poverty level. The federal
4 poverty level doesn't take into account the cost of living anywhere. And so you've got people in New York
5 City paying the same premiums as a rural, you know, you know. So there are a lot of things we could do
6 with premiums. But they can be -- they obviously are a burden.
7 MS. HENNEBERRY: We've always had premiums in Colorado as well, like, Alabama. And they're
8 fairly reasonable. And I think in the early days of CHIP it was quite problematic. Just because the target
9 population that we were serving, were people who had not been eligible for Medicaid and were uninsured.
10 They didn't have access to employer based insurance or, you know, we're very much a small employer state.
11 And -- or that it wasn't affordable.
12 So the very notion, it took a lot of work in the beginning just to educate people about what is
13 insurance? And how does it work? And how do you use it? And I think we're experiencing that same thing
14 all over again now through the exchanges.
15 But once people got used to it, I don't think it -- it's a huge barrier unless you have significant
16 change in circumstances. I think we just forget sometimes that the families on that borderline, right above
17 Medicaid eligibility into CHIP eligibility, you know, have almost all the same struggles. I mean, it's -- you
18 know, it's just -- life is complicated for them. And it's just hard to manage all the things they have to
19 manage every day.
20 The -- worse than premiums for us was the enrollment freeze. And I can't remember what year that
21 was. It was sometime while I was here in D.C. And it took years, literally, like three years for us to get our
22 enrollment numbers back up to where they were at the time we did the enrollment freeze. It just was
23 confusing to people. Am I in? Am I out? Am I eligible? Am I not? Are they open? Are they closed?
24 That was a real disaster for kids. Yeah.
25 MS. BROOKS: But I do think this is where more data is needed. And you can't just assume when

1 someone has cancelled for non-payment of premium that it's necessarily the reason they're leaving the

2 program. Sometimes they move out of state.

3 MS. HENNEBERRY: Sure.

4 MS. BROOKS: Or, you know, something else happens. But this is where I think that our -- the

5 performance indicators, the first phase of them, are not going to be robust enough because they don't have

6 denial and disenrollment reasons. And without those reasons, it's hard for us to really work on improving

7 how we retain people without knowing exactly why they fell off to begin with.

8 COMMISSIONER CHECKETT: Right. Well I think in particular with the launch of the

9 exchanges in the marketplace; this whole issue of the impact of premium. As I think you said so well, Joan,

10 you know the idea that, you know, you're paying premiums for perhaps the first time and what is insurance

11 are also big issues. So, thank you very much.

12 CHAIR ROWLAND: All right. I have Norma. Then I have Sharon. Then I have Mark. And then

13 I have Andy.

14 COMMISSIONER MARTINEZ-ROGERS: It was great listening to you. Thank you very much

15 for your presentation. I'm from the State of Texas and we have one of the highest rates, if not the highest

16 rate, of uninsured children in the United States. And I have a tremendous concern that -- about the mental

17 health issues that we have, the behavioral issues that we have.

18 One is that, as we move through this process of the ACA and whatever else we're going to do since

19 we did not expand any of our programs in Texas. I worry that primary care providers are going to think

20 that they can treat the problems of children that have behavioral problems.

21 And because of the lack of mental health professionals in the State of Texas and because of the fact

22 that in the rural areas, there are no mental health professionals, I'm wondering what would happen -- why in

23 Texas people aren't enrolled in CHIP programs? The children aren't enrolled in the CHIP programs. Do

24 you have any data related to that?

25 MS. BROOKS: Well, Texas, um, I think for a very long time, although in the past couple of years

1 it's gotten better, had a pretty bad eligibility system and a very low effectiveness in coordinating CHIP and
2 Medicaid. And I think they actually, you know, certainly have made some gains in that regard.
3 But what we know works in terms, because you do have the highest number of insured children or
4 the second highest, both in terms of percentages as well as numbers. And there has been progress. We can
5 see that. We actually, next week, will be releasing a brief that we've done for three years now on uninsured
6 children and looking at, you know, the trend using the ACS survey.
7 And so Texas has been showing some improvements. And I think that's partially because of some
8 of the fixes to the systems. We certainly explored that last year with the broader stakeholder community.
9 But what we know works, works across the country, if you put your time and energy into it. And
10 that is, you know, outreach, simplification. So you still had an asset test in Texas. And that's got to go away
11 with the ACA. So that's, you know, was a primary barrier.
12 And, in fact, I think, you know, there are concerns with your new ACA compliant application
13 because it still asks about assets and resources and doesn't say that it's optional. So those are examples of
14 what the State does, you know, to just create those barriers. And it's just, like, it's an attitude that you take
15 of being exclusive rather than inclusive. And, unfortunately, Texas has chosen to stay back where a lot of
16 agencies were, you know, 15 years ago and hasn't modernized as much.
17 COMMISSIONER CARTE: Thank you, both, some just really excellent observations. And
18 something, a question for both of you. Tricia, I really think that was a great suggestion about the
19 performance bonus perhaps being redirected or optional for -- I don't know how you would best
20 characterize it and --
21 MS. BROOKS: Redesigned.
22 COMMISSIONER CARTE: Redesigned for quality indicators and hopefully more value driven
23 care. But I do wonder if you have any concerns about, there could be additional cost to really realize a
24 robust children's preventative benefit. And especially bringing in social support, things like that.
25 It's been a concern for me in West Virginia that, you know, when we talk about the triple aim or

1 value driven care, that for the adult population that's much more readily realizable with chronic care and
2 with children, less so.
3 So, I'd like you to comment on that. And, Joan, I really -- I think you hit the nail on the head when
4 you talked about the CHIP transition in the future be precipitous or planned? That, I mean, to me that says
5 it all. And I just -- if you think that's an overstatement, I just remind everybody, that this is November
6 2013. And it had not been for a very committed champion of CHIP, Senator Rockefeller, CHIP would be
7 about to go away next month.
8 But, Joan, how would you see -- how could we realize the one big children's program vision and still
9 keep some of the guarantees of CHIP as it transition -- the promise of a child focus program as we go
10 forward to something different?
11 MS. HENNEBERRY: Well, I'm not sure I can answer that final question quite yet. But, I -- it's
12 pretty clear that with lots of support from CMS. I mean, I would say states have more opportunity and
13 more flexibility and more support to experiment today than they ever have in the history of these programs.
14 But the activity, and the leadership, and the planning, and the investment, and the innovation is
15 going to happen at the state level. I mean, you still have to have that permission, and support, and guidance
16 and some resources from the federal level. But the work is going to take place at the State level I think.
17 And so, you know, states are going to -- you know, a couple of them are going to have to step up
18 and say, we're going to go for this. We already covered most of our kids or all of our kids. We want to do
19 something different. We want to link it.
20 Now related to your first question, I would say, I think, maybe we've somehow done ourselves a
21 disservice by, you know, throwing this thing out there. Oh, let's all -- let's cover the kids. They're cheap.
22 They're easy. They're healthy. Well, that's true for most kids, thankfully. But even there, you know, you
23 have a state like Colorado where we are the only state left that has, you know, a low obesity rate among
24 adults, under 20, I think, or 25 -- under 20, I believe still. But our kids are getting more and more obese.
25 Well, something's not working there then. We have -- we have coverage for kids. We have

1 good safety net systems. We have the right financing. We believe in what we're doing. We have organized
2 systems. And yet there's a big thing that's getting missed there in terms of nutrition, and exercise, and the
3 understanding of healthiness for young kids. So, that they don't get to the place where it's going to be really
4 hard and difficult and expensive to fix that.

5 So, I just raise that as one example that I still think we have a lot of work to do with kids, even when
6 we have coverage and access. In terms of, what are the things that you need to do for them that will really
7 get them healthy and keep them healthy?

8 And -- and that's why new delivery models and case management and, yes, states are going to have
9 to make some upfront investments. It's actually, in some ways easier with kids, because of the opportunity
10 for EPSDT funding and enhanced reimbursements.

11 But I just think there's still plenty of work to do even when you have good coverage levels. We did
12 mental health parity for kids between CHIP and Medicaid in 2008, 2009, before anybody required it. And
13 does that mean that all of our children in public health insurance programs are getting the assessments and
14 interventions and treatments for behavioral health that they need? Absolutely not. And we've been at this
15 for a while. And there's a lot of work to be done there still.

16 MS. BROOKS: So, Sharon, you know, sort of the heart of your question. You know, if we were to
17 have an incentive program to improve quality, does that cost more money? Well, it could, in the short-run.

18 And I think the point with performance bonus was to provide incentives and to help states cover
19 some of those additional costs of enrollment when they did the simplifications that were required in order
20 to earn the bonus. So I think that partially offsets.

21 One of the things I often hear from the states and I think this applies, you know, to a lot of different
22 things. Is that we talk about data and comparing state to state. And, you know, once -- and states are
23 concerned about what that looks like. And I think we have to focus that comparison on not saying this
24 one's better or that one's better. But you can see where you might look for best practices or certainly where
25 you need to show improvement.

1 And I think that any incentive program that needs -- that has improvements built in should be
2 customized for the state rather than them -- you're saying, here's your target. You need to have 70 percent
3 dental access. Instead of that, if state A is at 50 percent and state B's at 30 percent, then let's both lift them
4 up. So that we're not saying, you both have to get to 70 to earn a bonus but the 30 state has to get to 35 and
5 the 50 state has to get to 53. So that you're using their own experience for improvement in a way that
6 doesn't make it competitive or too hard to reach for states that have more work to do.
7 COMMISSIONER HOYT: I had a question related to your comment that I thought was good
8 about being deliberant and thoughtful in decisions we make about changing the program. I wondered if
9 either of you'd care to comment on what you see as the biggest gaps in data reporting evidence that we
10 would need to do that research. So that we don't get two years down the road and then smack our forehead
11 and go, oh, I wish we'd asked for that.
12 MS. HENNEBERRY: Well, we actually developed in Colorado, somewhat modeled after New
13 Hampshire, also an all-payer claims database. I mean, we are big believers in data driven decision making.
14 Again, we're not there yet but we are at least trying to put the instruments in place to be able to collect and
15 report data through -- both through the all-payer claims database.
16 Through our state data analytics coordinator that we hired to help with the Medicaid program; to
17 collect and report almost real-time data that's fed back to providers. So that they understand exactly what's
18 going on in their practices and their panels and with their own patients.
19 I will say that the -- my observation of -- and some -- a couple people alluded to this earlier. The
20 challenge right now, even when you have very robust data and data other than just administrative data which
21 was, you know, typical many years ago. You had claims data and you didn't know what to do with it and it
22 didn't tell you anything.
23 Even when you have these now robust data sets, you still have to have analytic capability. And I
24 think it's unrealistic to expect at the community and provider level, that they would have that capability on
25 their own to understand what the data is telling them. So that they can actually act on it to help improve

1 care, or help manage their clients better, or educate their patients better.

2 And it's getting to be a real problem at the state level as well. State agencies are really stretched very,
3 very, very thin. I mean, the amount of work they've had to do to implement the ACA is really almost
4 inhumane. And they, you know, they don't have the talent or the resources either.

5 We're very fortunate in Colorado that we have a number of large health foundations that are major
6 investors in the work that we do to improve health and healthcare. But not everybody has those either. But
7 it is an investment and it's a skill set and a talent that is special. It's not something that everybody has in
8 their own organization.

9 MS. BROOKS: And one other thing that I would add to that is that we tend to do a lot of -- we
10 jump in and do special studies. You know, all of a sudden there's a hot button. And we jump in and we do
11 this study and we identify problems. But then we don't have that, sort of, ongoing continuity of being able
12 to look across, you know, when we do interventions to see that they're -- that they're sticking.

13 So, I think that, you know, if we can figure out a way to be more fluid and consistent in some of the
14 data that we do collect, that it would be very helpful.

15 COMMISSIONER MOORE: There was a -- if I can just quickly comment. There was a great --
16 two sessions, a Medicaid directors are -- were just in town meeting. There was a session on quality data.
17 You know, all the quality indicators, you know, HEDIS, and CAHPS, and NCQA, and state driven, and all
18 sorts of quality and outcome measures.

19 And then there was a session on performance measures. And it was astounding to me that the
20 amount of information, that states are now collecting and analyzing and paying attention to, to help them
21 understand what's happening in these public programs.

22 Everything from what I referred to as minutiae. How many times do you have to call someone, or
23 write letters, or send letters, to get them to even come to your door to enroll? I mean, that's just a -- one,
24 tiny, little data point, administrative performance data point to, you know, outcomes based data on did the
25 procedure -- are the procedures that you're paying for actually curing people?

1 I mean, so there's this enormous complicated continuum of performance and outcome measures
2 that Medicaid programs are -- they're doing some amazing things with this that's quite different than 20
3 years ago.
4 COMMISSIONER COHEN: Thank you so much. This has been such an incredibly helpful
5 presentation. And I think it has, both presentations and the staff work and everything has really, sort of,
6 moved the needle for the commission in terms of thinking about not are there issues, you know, that really
7 need to be resolved and thought about but to really starting to pin down what they are.
8 And one thing that I have been struck by is that a number of the issues -- and I'm going to assume
9 for the moment that, at some point, we'll have an exchange and mark-up place system that's functioning as
10 it was intended to function, which again may not address all of the issues. But just assume that for one
11 second.
12 There are some issues that you have identified that strike me as ones that could and I'm not trying to
13 say that they would. That could very -- could be addressed by policy fairly easily. And that's, you know,
14 affordability and cost sharing, benefits, eligibility and enrollment. Those are issues where if you write the
15 rules the right, you know, the right way and you -- you can do a good deal of alignment and make common
16 sense.
17 But there are some issues that you've raised, that I think really go to structure and that are harder to
18 address by policy. And I just wanted to -- I am sort of throwing out my theory of the list that seems more
19 easily amenable to policy solutions and then those that seem less.
20 And the ones that seem less to me from what I've heard you say so far today. And I think this is
21 probably an incomplete list. One is the, this sort of intangible about branding, community engagement and
22 support around the issues of children. In particular, that it just, sort of, being able to develop a community
23 focus around children as a population has -- has some benefits; maybe very, very significant benefits.
24 And the other one is this, sort of, quality focus. And this idea that in a plan that serves a very, very
25 wide variety of populations, if you had, you know, there's only so many quality measures that you can collect

1 and manage to. And if you have 20 and it's a mixed population, maybe one or two are going to be pediatric
2 focused or three or four. And if you have a kid plan, it's going to be 20.

3 So, anyway, I'm sort of throwing that out for your reaction. And also maybe some completion of
4 my very brief list of what are sort of -- of what you see as more policy amenable changes and those that are
5 not.

6 MS. HENNEBERRY: Well, I think you're right. And I would add to the, kind of, the non-policy.
7 You know, the interoperability, the interfaces between systems and the -- just the work to make -- even in
8 states. Even within the states that built their own exchanges that, you know, things are working okay. In
9 the back room, you know, they're having lots of challenges. And they're working them through and they're
10 doing what they're doing. But it's not easy there either.

11 So, I think all of these, all of these -- technology, whether it's, you know, intrastate, interstate, you
12 know, whatever. Those are challenges.

13 I do think there's some key policy questions. I mean, I don't -- I'm a born optimist. But some of
14 the things that could be policy options to address some of these things have to be done here, in
15 Washington. States have to have permission and authority to do some of the things that they know they
16 could do to fix some of these issues. And I don't know, you know, see an easy pathway to getting some of
17 these things discussed in Congress that would allow for this to happen.

18 You know, one, one obvious one is, you heard the state folks say, states really haven't paid much
19 attention to this. The numbers of kids who are going to be enrolling in the exchange through parent plans.
20 And states have said, they're paying a lot of attention and trying to manage to the movement between
21 Medicaid and the exchange, because the adult population. But they are -- they'll tell you right out. It is not
22 on the top of their to-do list, to think about the churn and movement between CHIP kids and kids going
23 back and forth to the exchange.

24 And yet, that's going to happen. And we don't know enough yet about that and states haven't
25 figured out what they're going to do about it. But one thing you could do, at the policy level, is you could

1 give families the option of taking their CHIP money with them and letting them use that money to pay the
2 child's portion of the premium; can't do that now.
3 And if a family -- remember my question earlier? We don't really know how important it is to
4 families so I'll be in the same plan. We think it's important. So if it is important to that family and they say
5 it's important, then let's make it easy for them. And we can't do that right now.
6 MS. BROOKS: The thing I would really add is that I worry about where our country is politically,
7 not only here in Washington but also at the state level about, you know, being innovative and focusing.
8 There -- it's -- we're not in a great place. And so, I do think that impacts a lot of things. I think we have a
9 lot of work to do in building support for continuing CHIP here at the federal level.
10 There, you know, I remember Joy Wilson at the Medicaid Congress, you know, talking about the
11 number of new legislators across the country. And, you know, it's astounding sometimes that they can't
12 actually describe what Medicaid is or what CHIP is. So, you know, I think that remains, you know, a
13 barrier. There's a huge education ongoing that's needed but also somehow we need to stop the gridlock and
14 figure out a way to compromise and make some value based decisions.
15 VICE CHAIR SUNDWALL: I'm just going to -- thank you very much again. I'm just going to
16 make a comment as the only clinician. I don't know, Steve, if you see people. But, I -- you know, our
17 enthusiasm for data and accountability and monitoring, I can't tell you how burdensome it feels as a
18 practicing doctor. And I don't know what pediatricians are required to do to get more data --
19 CHAIR ROWLAND: And midwives.
20 VICE CHAIR SUNDWALL: What? And midwives. Oh, I'm sorry, clinicians. You're right. And
21 you know what I'm talking about.
22 COMMISSIONER CHECKETT: I think you've got a lot of clinicians around the --
23 VICE CHAIR SUNDWALL: Then I speak for my colleagues on the commission.
24 COMMISSIONER CHECKETT: I think you better save yourself quickly.
25 VICE CHAIR SUNDWALL: I think -- I know I'm sounding like a --

1 COMMISSIONER CHECKETT: Or you're not getting lunch.

2 VICE CHAIR SUNDWALL: I sound like a parochial doctor. Forgive me. But seriously, you
3 know, we are glad we have these data systems. But -- and you say states are doing a lot of good with them.
4 We have an all-payer claims database in Utah and it has great potential, which has yet to be realized.

5 But it really is, in the name of quality measurement or accountability, it's just choking. And I hope
6 the commission will understand that we really need to be very prudent in what we recommend as more data
7 to gather or how we can use it better. Because I think there's a lot of data sets that aren't used at all. We've
8 talked about that before.

9 Just recently they've come out with new information to suggest what pressure we were under to do
10 the cholesterol guidelines is wrong or at least it's been updated. And things we were chasing aren't
11 necessary; same thing with hemoglobin A1c's. And our payment rates are based on if we achieve some level
12 which now proves to be illusory.

13 So, anyway, I'm just trying to put a pitch in for us, clinicians, who are required to do all this data --
14 provide all this data, that we wonder if it's productive or not. And it certainly is costly and cumbersome.

15 CHAIR ROWLAND: Well, I'm going to put a pitch in for our policy analystS and all of our
16 commission members to say, that I thought this panel has really helped us to have a broader view of the
17 issues that we're facing. It's not really the future of CHIP. It's the future of coverage for children and how
18 children are best covered through all of our systems.

19 And you've done a tremendous service to us by laying out many of these challenges and issues. And
20 we will be struggling with this, as you are, to try and make sure that we don't leave any of these children
21 behind in the reforms going forward. But that we end up hopefully with a set of recommendations that will
22 lead to better care and better coverage for children. So thank you very much. And now we'll adjourn for
23 lunch. We'll let David eat actually. And then we'll reconvene at 1:00 to hear about the Long-term Care
24 Commission. Thank you.

25 [Whereupon, at 11:49 a.m., the meeting was recessed, to reconvene at 1:00 p.m. the same day.]

1 AFTERNOON SESSION [1:05 P.M.]

2 CHAIR ROWLAND: Please reconvene.

3 And I want to welcome Bruce Chernof and Mark Warshawsky here to talk to us about the work of
4 the Long-Term Care Commission and its recent report. We all marvel at the time frame you had to
5 complete your work and the amazing amount of work you accomplished during such a short time period.
6 It's set a standard that we on MACPAC are trying hard to achieve.

7 But I think your slides are up and we welcome to hear what your Commission considered and
8 developed as your recommendations.

9 **### SESSION 3: Long-Term Care Commission: Report from Commission's**
10 **Leadership**

11 * DR. CHERNOF: Well, speaking just for myself to begin, but on behalf of both of us, we
12 really appreciate the opportunity to come chat with you.

13 We thought a little bit about how to do this and there isn't sort of a good way, so I'm going to take
14 the liberty of running through the slide deck fairly quickly, and then Mark will make some comments as
15 well.

16 And more importantly, I think we want to have a discussion with all of you. And a lot of this
17 material is familiar to the Commissioners, and so we're not going to sort of belabor the points that are
18 common knowledge for this group, but really talk about I think the process of maybe there's a good
19 discussion about next steps.

20 So with that in mind, before I go too much further into the presentation, I actually really, I try to do
21 this in every opportunity where we work together. You know we wouldn't be here today if it wasn't for the
22 process that we put in place and really the benefit that Mark brought as my co-chair, vice-chair.

23 We were committed from the get-go to try to define where a broad common middle existence,
24 because if there is anything true about this phase, is that folks tend to go to a preferred set of solutions and
25 then the problem looks completely intractable. And I think we were committed to making the case that

1 trying to advance a better approach to service delivery, to work force, and to even the tough questions of
2 financing. There is a way to have a discussion that leads to consensus and the ability to move forward.
3 So with that, that's just kind of our general opening comment. We were very lucky to have Larry
4 Adkins serve as staff director. He put together a really good team and our report on the slide deck is really
5 the product of the Commissioners themselves, but also the product of a really wonderful team.
6 Ah, there we go. So from a statutory perspective, you know, we were created out of the fiscal cliff
7 law, and we were required to develop a plan that really looked at building a better long-term care system,
8 and one that insures availability for all those who need it, really address a whole range of populations, not
9 just adults, but those with substantive cognitive and functional limitations and other folks with needs as
10 well, younger individuals who work, for example.
11 As we looked at our charge, the notion that we were going to get this all done within six months,
12 that we would have a detailed report, that we would have everything not just in a report, but in legislative
13 language, seemed like a really tall order for all of us.
14 So we began our work, our six-month work with a 90-day time frame. We started in June of 2013.
15 We had our first meeting at the end of the month. We were -- we had a very active summer, so what, you
16 know, that summer book report, "What did you do during your summer vacation?" Mark and I have quite
17 the report we can write.
18 We actually had a total of four public hearings. We heard extensively from folks. We tried to hear
19 from real thought leaders. We also tried to bring in voices that had not been heard to broaden the
20 discussion. And we had extensive public input, even in the very short time we had, and then met in nine
21 executive sessions to produce the final report.
22 Again, our goal was a broad process. And I'd be glad, we'd both be glad to talk a little but about the
23 process that we used.

1 Leave it to say that on the final day of our commission, we had a 9-6 vote in favor of the report,
2 about equally split between Democratic appointees and Republican appointees. And glad to talk a little but
3 about what got to approval and what go to descent.
4 The report itself is broken into a few key parts. There's a call to action, which we thought was very
5 important, simply because this -- we believe this report is targeted at a broader audience. For every
6 Commissioner in the room, you all know this information, so I will run through that piece fairly quickly.
7 We then went on and put together a total of 28 recommendations, including that had been brought
8 by partisan support, as well as two approaches to dealing with the challenges of financing.
9 I will say that in the very short time frame, I'm not sure that the Commission could have gotten all
10 the way home, and we felt very strongly that laying out the perspectives on financing were important, and
11 we'll both talk about that at the end.
12 So again, the report has a call to action. We look at some of the specific challenges. There's
13 recommendations and service delivery, workforce, financing, and then a final chapter about how to advance
14 the agenda. You all are part of that. I think part of why Mark and I are here. We look for every
15 opportunity to meet with folks like you, is that something needs to come next.
16 The Commission didn't say that it had to be one thing. It's too easy to shoot down one thing. We
17 do think that some standing process or processes, whether they are current bodies that are in place, like you
18 folks, or other bodies that should or could be created. That's for others to decide. But we think that there
19 needs to be a follow-up approach to the work.
20 Let me run very quickly through the call to action. So we all know that there's 12-million folks who
21 have need. It's a pretty diverse population. Mostly live in their homes and communities. Most are assisted
22 by family caregivers. And I think a really important point, because we grappled with this need question, is
23 that many individuals do get their needs met. Now, whether that's in the most efficient way, whether that's
24 a particularly person-centered way, whether that's an integrated way, is a different question. But you know

1 it's important to realize that for a lot of folks there are a set of services out there, it's just not how we would
2 necessarily want to organize them.

3 The populations that need or use long-term services and supports are very different, and so it is
4 important to recognize in these discussions that not everybody needs the same set of services in the same
5 way. And so one of the challenges becomes you know how do you bring together a broad based solution
6 that's responsive to the needs of specific age groups and communities?

7 So you know while lots of folks may get their needs met in some form or fashion, there is a growing
8 problem. So we all know that with the population aging there will be more folks who need services, yet
9 family care givers play an incredibly important role, do now, always will. The nature of that role will only
10 become more stressed over time. I just point out that demographically, we have way -- we have way more
11 people who live alone in older life. We have far more children who live away from parents, smaller families.
12 So what will the caregiving network look like for the next generation of older individuals who need long-
13 term services and supports, whether they develop that need in older life or whether they had it across their
14 lives, starting out as a younger disabled person?

15 Long-term services and supports can be really expensive. You all know the data. It's a long, lazy
16 curve, right? So you have something like 30-percent of people over the age of 65 who need no long-term
17 services and supports. And you have 20-percent or so of people who will need five or more years. And
18 then you know that three-year divot point in the middle is the middle, a little bit of support for about three
19 years. But it's a broad range and it's hard to predict what any individual will need.

20 Medicaid is clearly the largest payer. I think if Mark and I had a message for all of you, it is that you
21 know the null hypothesis, which I know nobody in this room believes, but you all see this in your work.
22 The null hypothesis, which is, "We are busy doing other things and we'll get to long-term care." The null
23 hypothesis is far and away the most expensive hypothesis, because doing nothing just sort of perpetuates
24 inefficient systems, systems that are not particularly person-centered, things that aren't good use of public or

1 private resources, nor do they create a new range of tools and solutions that people could potentially pull
2 down and use. So I think this notion of "We need to think differently in this space," is very important.
3 Moving quickly through the call, direct care workforce is incredibly important. That's something
4 that you all know. It's a workforce that despite lots and lots of I think support for their role, I will just say
5 for me, sometimes it feels a little like lip service and we need to get our commitment lined up to a well-
6 trained workforce with -- we need our commitment to line up with our rhetoric around having folks in the
7 community who are there to provide care. As a physician, I'll say to all of you, at the end of the day, the
8 hardest job in any delivery system is the place where there's the greatest uncertainty. So for me it's not
9 being in the emergency room bay in the back. It's actually sitting in the emergency room waiting room.
10 And people don't know whether you're the catastrophic heart attack or the, you know, cold that's gone on
11 for four months.
12 Those -- and the same thing is true when you send somebody into a home. I mean they're in often
13 the most uncertain circumstance, and maybe most -- maybe most prepared to understand whether there's
14 been a significant change in status.
15 Long-term services and supports are highly fragmented, difficult to access. That's something that
16 needs to be addressed. With just the growth of the population, even with disability rates going down,
17 there's likely a substantial increasing need. This slide just makes the case that there will be substantially
18 more folks who will need support over time.
19 As we think about that projected need, we're going to have to confront resource constraints. So I'm
20 a Democratic Appointee. I'm here to tell you, as a Democratic Appointee, and I think Mark would say the
21 same thing from a Republican Appointee perspective, we need to solve problems in the context of where
22 we are as opposed to the context of where we'd like to be. And part of this is using resources more
23 efficiently. Part of this is helping people plan better. But these are difficult times in which to make change,
24 and I think the Commission is well aware of that.

1 We do think that there are things that could change the direction of how care is delivered, so we
2 actually spent some time thinking -- a lot of time, frankly, thinking about care integration, the use of new
3 technologies. We think these could be very important. And I'll just observe that we all need to be a little
4 thoughtful about our projections for the future.
5 So as a general internist who started his career at the beginning of the AIDS epidemic, you know,
6 you would see sort of statistics about what things would look like. And you know we've now gotten to the
7 place with highly active retroviral therapy that people live a really long time. And that wasn't in people's
8 mindset early on in the course of that. And so I think you know there -- will Alzheimer's treatment therapy
9 look really different 10 years from now? The answer is probably "Yes," but none of us know what that
10 looks like. And so it's a little hard to read the crystal ball, because those projections are sort of based on
11 where we are and you don't see the disruptive change that will likely occur in some places, particularly in the
12 direct care delivery side.
13 We really believe, even though -- and it's something I think we both believe, and the Commission as
14 a whole believes, is that creative financing solutions are needed. And even though we didn't get to a single
15 recommendation, two approaches were laid out.
16 And I think that we, as a Commission, all really believe -- I think it's a very important message for all
17 of you. If you look at both the financing approaches that are laid out, this notion of a strong appropriate set
18 of safety net programs, public programs that are there for those who need them, is incredibly important.
19 And shoring up Medicaid is one of those really important things that needs to be thought about. Now, how
20 one does that and who it targets, that's a really important question. But you know the Commission was not
21 tilting at windmills. It was not a Don Quixote exercise. And I think there is this notion that we need
22 Medicaid, you know, visible and sized in a way that is tailored to the needs in front of us.
23 So taking it all together, the Commission put together a vision. I'm not going to read through this
24 slide. You will have it. But I think more than anything, the Commission had as an operative principle that
25 person- and family-centered care should drive decision making and planning. And that really if we want to

1 get to higher quality, lower cost, more integrated care, if we just could keep the -- particularly the person and
2 the family in mind, that was a really good starting out point. And it was kind of a litmus test that we went
3 back to even when we were having difficult discussions. The vision is laid out in detail in the report. This
4 visual just gives you a sense of some of the key points that we thought drove the vision.

5 When it came to service delivery, right, there was a set of 28 recommendations, and I just want to
6 touch on each of these quickly, because it's relevant. It was great to see Democratic and Republican
7 Appointees come together on the notion of rebalancing, and this is a really important point, because
8 rebalancing can be a loaded word in some circles. But this notion of incentivizing states that balance home
9 and community-based services with the institutional services and really figure out how to do that is
10 incredibly important.

11 The Commission thought that care integration was incredibly important. And for care integration,
12 we're really talking about aligning incentives to encourage the integration of care. So it's things like a single
13 plan of care, a single plan contract, the use of technology to mobilize and integrate resources.

14 And kind of a broad recommendation that not all of this needs to be done on the back of public
15 programs or private insurance resources, but communities solve these problems for themselves to a large
16 degree, and that we need to be very mindful of the fact that leveraging those resources that are there and
17 having them be part of the system as opposed to outside the system, is part of how we extend successful
18 models.

19 Uniform assessment. Uniform assessment. Uniform assessment. Ouch. Uniform assessment.

20 (Laughter)

21 DR. CHERNOF: If I could ask you guys to do one thing that would help drive the process, you
22 know, CMS has been determined to take out Mark's class.

23 (Laughter)

24 DR. CHERNOF: And CMS has worked on -- there's been a lot of work around uniform
25 assessment. CMS has spent a lot of time developing a product that has yet to see the light of day. And I'm

1 not trying to be hypocritical. But to a "T", Commissioners felt that this was incredibly important and we
2 need to stop talking about it and start doing it. And you know any starting place is better than where we are
3 today.

4 I want to just acknowledge that this notion, holistically, of shifting towards community based care,
5 has been in place for a long time. You all are aware of these data. We think they're very important and they
6 need to be encouraged.

7 Further on service delivery, consumer access really expanding the notion of "No Wrong Door."
8 Building out quality measures that, frankly, get at what it means to receive services and long-term services
9 and support systems.

10 And so let me say what that doesn't mean. It's not one more set of hedis data about chronic care.
11 And it is not one more CAHPS survey that you know interviews people once a year. It's not that you can't
12 build on those things, but we need quality measures that really get at the quality of the care delivered in
13 community based systems, and we need to get data about the quality of people's experiences, because this
14 gets at the quality of life as opposed to kind of the sort of quality of health and medicalizing of the long-
15 term services and support systems.

16 And until we can answer really important questions, simple questions -- I'll give you one. I'll give
17 you three. How confident are you -- how confident are you that if you had a problem as an older person
18 with a serious chronic illness and some functional limitations, that you would know what to do with that
19 problem? How confident are you that you could call one person who would be able to help you? And how
20 confident are you that you could reach that person?

21 I mean that kind of simplicity and quality is really missing and that the longitudinal nature of the care
22 delivery process for those in long-term services and supports is really important and completely not
23 captured by the current tools that are available.

24 We think payment reform is incredibly important. It was actually really interesting to see
25 Democratic and Republican Appointees come together to really see the importance of the focus on

1 outcomes as opposed to site of service, and the move from sort of -- not so much the move from sort of
2 fee for service to capitation that this notion of really focusing on outcomes and focusing on getting services
3 to people in a way that they want to receive them, as opposed to where the bricks and mortar would prefer
4 to deliver them, because actually reimbursement encourages those models.
5 On the workforce side, family care giving was an incredibly important area and another section that
6 I really call out for your attention.
7 And one key point was the need of a national strategy to obtain and strengthen family caregiving.
8 And then being more kind of granular for a sec, that family caregivers need to be part of the assessment in
9 care planning. And let me be very specific what we mean by this. We mean that the caregiver should be
10 identified in the medical record and assessed as part of the plan of care. So when you look at the
11 recommendations, it's that level of detail. And finally, that we need to do things that could support
12 caregivers in their role.
13 And this section gets a little bit of things like respa care and how would one begin to think about
14 those things.
15 And then on the paid workforce side, we made some specific recommendations, because I do think
16 the Commission, as a whole, felt it was very important that direct care workers weren't called out in some
17 way that wasn't really relevant to every worker, every healthcare worker, professionalized or not. And so
18 this notion of -- notions of taking on the scope of practice question -- and I will say as a physician, it is a real
19 problem that we have this whole "Yes, but" world. Yes, we believe in teams. We all want to be in teams.
20 Team care is lovely, except I don't really want to delegate what I want to do to nurses. And you know from
21 nursing to delegate within itself or to other disciplines, it is a real problem. It is a real problem. And until
22 we can get the professional disciplines in the direct care workforce, the right set of tools to operate as a
23 team, that's going to be a problem.
24 And I think this was very frustrating for many of the Commissioners who really brought a State level
25 perspective, because this -- much of this operates at the State level.

1 We also thought it was really important that this notion of criminal background checks is important
2 and it is very fragmented across the United States. And it's not just the direct care workforce. Anybody
3 who goes into somebody's home needs to be safe. And so the rules of the game should be the same for
4 everybody, not just as a direct care workforce employee.

5 With respect to the direct care workforce, a lot of focus on what it would take to create meaningful
6 lattice and lattices for career advancement, you know, the turnover and preparedness for the direct care
7 workforce is something that received a lot of attention. And integrating direct care workers into care teams
8 and fundamentally taking on this issue of delegation was important.

9 Finally, we, you know, I think as a Commission, there were a number of places where we bumped
10 into this issue, and this was one of them, where there isn't good data. And I think the Commission felt it
11 was very important that we not just work off of suppositions. And there were places where, frankly, the
12 data was really blank.

13 I will say that the data is pretty weak on the younger disabled population. Not as much is known
14 about those communities as is known about the older disabled population. And there isn't enough
15 thoughtful comprehensive data about the long-term services and supports workforce at this point, and we
16 felt that this was a place that CMS and others needed to pay more attention.

17 Finally, we thought there was value and, you know, we left it open where this should occur. So is
18 this a place where there's a Federal floor? Is this a place that -- this is a very important place for where
19 states are. So the recommendation stops short of being highly specific. But this notion that there should be
20 standards and certification for homecare workers and how we get there is an important question. And, one,
21 where you all may have a perspective, given how Medicaid operates in all the states, and you guys could be
22 the drivers.

23 You know, financing, there were two separate approaches. That is as far as we could get in the time
24 we had available to us. What was very important is that there was this common vision, and I want to
25 highlight this for you, because I think it lays the roadmap for what needs to come next in this space. You

1 know, I was really taken by the fact that this notion of strong public programs identified and shored up for
2 what they need to do was a critical point. You know, fundamentally, people are not saving and are not
3 planning, because there are not -- there are not -- are not a set of accessible, available, appropriate tools for
4 the most part to help them do so. And how much of it is supply and how much of it is demand, a lot of
5 work to be looked at in this space.

6 But basically, you know, there's this need to have strong programs and people need to have
7 resources to plan with. And without a set of tools for people to plan, it's really hard to expect there to be a
8 strong safety net.

9 And this goes back to that null hypothesis one more time. Doing nothing is far and away the most
10 expensive solution for Medicare and Medicaid.

11 Like I said, the Commission didn't agree on a single approach off this common vision. There was
12 one approach that was predominantly focused on private solutions that could strengthen financing, one that
13 predominantly looked at social insurance models or public approaches. But I think what was key for me is
14 that if you start to read those reports, you can start to see where the overlap is. You know, whether we as a
15 Commission could have gotten all the way home on a singular recommendation in a highly political
16 environment, just this very moment, I don't know. But I do think that the notion that there is a pathway
17 forward with something that all Commissioners believed in and do believe that with the right group of
18 people on the right process we could get there.

19 We made some specific recommendations around Medicaid. We think that there specifically needs
20 to be a new demo to provide long-term services and supports to person with disabilities to help -- who are
21 employed, to help them remain employed, so that this allows individuals to not have to give up employment
22 or have problems moving from state to state because of differing rules within Medicaid, and that the LTSS
23 services provided through Medicaid could be a gateway to helping younger people with serious disabilities
24 live a, you know, a complete life, including one with work and professional responsibilities. And again, sort
25 of linking to that, assisting states to achieve greater uniformity in Medicaid buy-in programs.

1 Finally, on the Medicare side, you know, we think Medicare could use some sprucing up. We, you
2 know, I think the Commission was very mindful in its work at all times in that if we make
3 recommendations, almost every rule that's in place was there to solve a problem that somebody either saw
4 or believed would occur, and, you know, the unintended consequences of taking away barriers is something
5 that one needs to do cautiously.
6 But I think the Commission, as a whole, really felt that the use of the three-day prior hospitalization
7 rule for (inaudible)stays was causing odd behaviors in the interaction between the pre-dated prior
8 hospitalization rules and the use of observation stays, justee stays, was creating a substantial challenge in
9 building appropriate transitions and care for those who need long-term services and supports, and causing
10 people to use patterns of care that were actually not only fragmented, but more expensive.
11 We're almost there, guys. You've been very patient.
12 You know, savings, we thought it was very important, and there is a piece of legislation that's
13 moving now that would allow individuals with disabilities and their families to set up 529 savings funds.
14 This is like, just to give you the parallel, it's sort of like savings for a child's college education. And what the
15 specific recommendation was about was allowing others beyond just the direct family of that child to
16 potentially be able to help put savings away over time.
17 Next steps, the Commission really, really, really, really -- I guess that's enough really's -- believes that
18 there needs to be a next step. That developing a comprehensive program to organize and finance long-term
19 services and supports was not going to be solved in 90 days, and candidly, it was not going to be solved in
20 six months. But we felt that it was very important to produce a product, particularly, post the rule of
21 CAHPS, which also occurred in that same piece of legislation.
22 The right way forward is going to be one that leads to a bipartisan balanced discussion, and that we
23 think that there are incremental substantial steps that could be taken, but there needs to be a way to do that.
24 And, you know, whether that's -- like I said, we made no specific recommendation about exactly how that
25 should occur, so whether, again, it's a body like this, whether it's a current body that exists somewhere in

1 CMS, whether it's a new body, whether it's congressional in nature, whether it's, you know, we think smarter
2 minds than ours, people who are not on their summer breaks, should give that a little thought. So, yeah, we
3 recommend it to the National Advisory Committee.
4 We also thought it would be very important for the White House to use the 20/15 conference on
5 aging to try to focus on this issue and this issue alone, and to try to make that discussion not just be about
6 aging, but about aging and disability.
7 We need to have a National discussion. That may be the last point that I should hit on. I think
8 everybody felt very strongly that helping educate the general public about this upcoming need that 70-
9 percent of us will face when we hit 65, is a missing piece of the puzzle and that the White House
10 Conference could be a good place for bringing up that discussion.
11 Let me stop. You've been very kind. I want to give Mark a chance to make some additional
12 observations, correct any errors I may have made, and then we're all yours.
13 CHAIR ROWLAND: Thank you.
14 * DR. WARSHAWSKY: Again, thank -- I also want to thank you for inviting us.
15 I think it's a very appropriate venue for us to talk, because you are the experts on Medicaid, and
16 Medicaid, as the data showed and as we discussed, is a foundation in this area. I think we tried to learn
17 more about exactly how Medicaid works, how it was intended to work, how it actually works, in terms of
18 LTSS and I'll come back to that, because I do have some suggestions for something that you might consider
19 in terms of the next steps in terms of study and discussions.
20 But let me start, really, with sort of to share the praise with Bruce and indicate that it was, you know,
21 his I think great contribution to this is to set up a process whereby it was a consensus process, it truly was,
22 but at the same time, it was a -- it created an environment where it was, if you will, it was sort of a safe
23 environment where everyone felt they could state their ideas and also be free to sort of discuss everyone
24 else's ideas.

1 And I think that is -- was a, you know, really a very appropriate and intelligent way of handling this
2 so that the report, and with all due consideration and thanks and really great appreciation to the staff, you
3 know, the ideas in the report mainly came, you know, from the Commissioners themselves. And so I think
4 that's important to not.
5 Another thing, I'll just sort of emphasize a few points that were in the slides that I think there are a
6 little more emphasis, a little more repetition.
7 There is an appendix in the report. And the reason why the appendix was included was because it's
8 basically an indication of all the ideas which the Commissioners put forward.
9 Now, we didn't have time and there wasn't perhaps consensus to discuss all the ideas, and so the
10 consensus was, you know, to focus on certain ideas and leave others for another time. But we wanted to
11 have some record of those ideas and that's what's in the appendix. And, you know, we encourage you to
12 consider those as well as what was actually recommended.
13 And also, as sort of to say something of a process as sort of the nine to six vote, you know, despite
14 the vote, you know, because of the way in which the Commission operated, the ideas and the
15 recommendations were truly everyone's ideas and recommendations.
16 And so the fact that some people voted for it or some people voted -- didn't vote for it, is no
17 indication, whatsoever, that -- it didn't mean that those who voted against it didn't have their ideas, any of
18 their ideas in the report. And I think that's worth emphasizing.
19 In terms of some other points, you know, we sort of split it in terms of populations between
20 retirees, the elderly, and the low 65 or working age disabled. And we found that in a way and I think Bruce
21 indicated this, that what's easier to think about the elderly and retirees. Number one, the data was better.
22 People really, and others, our and others have focused on it. There may not even be a consensus there in
23 terms of what the state of results of the literature are, but at least there is literature.
24 We were very surprised, and maybe it was just a matter of that we didn't have enough time to really,
25 you know, dig deep, there wasn't as much information on the working age disabled. And, therefore,

1 although we had, you know, a couple of recommendations, you know, this demonstration project. I mean
2 in a way that's the point, it's a demonstration project, because we want to learn more. But it would be great
3 to have even more information. And in order to do policy on this area, it's simply -- it's a vacuum of
4 information.

5 You know the budget issues, as first indicated, are really important. You know, they're important
6 now and they're going to be really important down the road. And I think one needs to be very, very
7 cognitive of that in terms of any solutions that -- and recommendations that are going to be put forward.

8 We did not have time -- I don't know if we -- even if we had more time whether we would have
9 gotten it. We didn't get scores, in our congressional budget office,scores for any of this. And so we were
10 doing this a little bit in the dark. I think some of us had an intuition that maybe all of this would be sort of
11 budget neutral in a way, but we don't know that for sure.

12 But, you know, as Bruce indicated on a couple of those, we thought that some of them, you know,
13 although they seemed to cost money may in fact, save money. And so -- but we don't know that for sure,
14 and that also is something that I think is worth further exploration.

15 And then, you know, I just want to conclude by saying something that I will recommend to you. In
16 addition to all the recommendations and to follow up on this, you know the question about the centrality of
17 Medicaid. So we did hear testimony about this, and I think it was -- there was -- I would say my
18 interpretation of it, reading through the presentations, is that it was not conclusive in terms of exactly, you
19 know, in terms of the role that Medicaid plays in preventing or discouraging personal preparation,
20 particularly for, at the point of being retired, for personal preparation and financing of these needs. I think
21 we certainly heard different viewpoints, but I think it's a very key question, and I would encourage you to
22 further that discussion and that exploration.

23 The other thing is just in terms of the way Medicaid works, the actual rules and their interaction with
24 reality in terms of again focusing on retirees and their budgets and their finances and their assets. We heard
25 about what the rules actually were, but even there, there was, you know, the rules are very complicated and

1 they differ from state to state. So we didn't have I think enough time and just enough resources, really, to
2 really explore the depths of that.
3 But it was really -- I think if those are key issues in understanding, and in the discussion of what, you
4 know, what financing ultimately might be recommended going forward, you just have to understand what
5 the current financing is. And we didn't -- we didn't -- we had presentations and we had discussions, but we
6 did not have a full meeting of the minds about that. In order for there to be a central financing
7 recommendation, we need to understand what's going on right now.
8 So the -- you know, everything that was first indicated is -- truly is a consensus and I
9 just wanted to emphasize a few more -- a few of those points.
10 Thank you.
11 CHAIR ROWLAND: Thank you very much. This is of course always helpful to have colleagues
12 come in and talk to us about their work and their deliberations so that we can understand where some of
13 the issues and challenges facing us are. Obviously, this group has also spent a considerable amount of time
14 looking at the under age 65 disabled population and the special role that Medicaid plays there and continues
15 to try and follow some of the work going on with the dual-eligible population and the efforts there to both
16 perform the way that works in some of the integration services.
17 But I'll open it up now for other Commission members to ask questions, and turn first to my vice-
18 chair David.
19 VICE CHAIR SUNDWALL: Yes, briefly. I apologize for missing the first part of this. I was on a
20 call with the Press, which is always risky.
21 But anyway, I have a curiosity. As you probably know, Medicaid was proposed by conservatives to
22 be block granted and given back to the states to get it off the Federal roles. And it made me think of my
23 early days in Washington when under the Reagan Administration (inaudible), it was proposed that long-term
24 care be block granted. Did that issue come up or did you get into that level of discussion of financing, and
25 if so do you think there's merit in that or not?

1 DR. CHERNOF: We'll both take a shot at this question. You know, I think -- I think it's
2 important to recognize what is in this report and what is not. And what I mean by that is, you know, there
3 are broad viewpoints about how one might fundamentally and radically change how we approach long-term
4 care in this country. And so one viewpoint might be, "We should build kind of a, you know, a big fully built
5 social insurance program that could stand, you know, alongside Medicare or Medicaid and social security or
6 potentially, you know, you could build it within one of those programs. But there's sort of, like sort of --
7 there's that kind of a comprehensive solve.

8 And then, you know, there is notions of -- and that would really sort of be a Federalized solve. And
9 then there's another approach that says these services are really basically delivered out of one community at
10 a time and often one state at a time, and we've built a lot of our structure to recognize that -- a very
11 important role of states delivering services. And, you know, block granting is one of those very broad kinds
12 of substantial concepts that would, you know, really, speaking just for me now, I think substantially change
13 the way the services are delivered.

14 And I think -- it's interesting to me that in the report, while we had a little bit of discussion about
15 both of those things, I think that the Commissioners as a whole, even though there were Commissioners
16 who strongly believe in both those concepts, let me be quite clear, you know, I don't -- the Commission
17 didn't see the value of pursuing those things in extraordinary detail, simply because our -- the charge that
18 Mark and I created for the Commission was, we wanted a product that was going to lead us to broad
19 agreement.

20 And our proof of concept is that there was a -- that there was a middle withdraw agreement, that
21 this is not an intractable problem, that there are substantial things that can be done today.

22 So with that being the goal that we set within our charge, the Committee -- the Commission, as a
23 whole, while it sort of entertain sort of broad concepts of which have more present support, of which have
24 more conservative support, those concepts weren't going to survive given the exercise that we put the
25 Commission through, in terms of making it into a final recommendation.

1 So I think for the Commission -- for individual Commissioners, it's not that those ideas don't have
2 currency or shouldn't be considered, but the Commission, as a whole, through the process we put in place,
3 really wasn't there to take on that kind of a recommendation.
4 So I'm not trying to dodge the question, but just to say that the process wasn't going to lead us to
5 either one of those kinds of solvents.
6 DR. WARSHAWSKY: And I'll just simply add that we did have some testimony, you know, even
7 in the selection of witnesses for our public hearings, it was a consensus process. So we did hear, I believe, if
8 my memory serves me correctly, from folks from Rhode Island, which had some ideas, I don't know if, per
9 se, it was a block ideas, but some ideas in the financing of Medicaid, which, you know, were viewed as --
10 some people viewed it as controversial, so that we certainly heard about that, those ideas and those
11 concepts. And I think they were included, again, in the idea appendix.
12 But, you know, just echoing Bruce, it was a consensus process. So some Commissioners felt very
13 strongly about that and they were discussed.
14 CHAIR ROWLAND: Next.
15 COMMISSIONER RILEY: This conversation always makes me feel so old.
16 (Laughter)
17 COMMISSIONER RILEY: I am recalling a White House Conference on aging maybe 35 years ago
18 when the topic was Uniform Assessment, because the states were moving there and it was a frustration that
19 we couldn't get the Federal Government there, and I think states have been leaders in that area. But it's -- it
20 is a little frustrating to think the same topics come up over and over again, but good that we keep pushing.
21 I want to talk a little bit about the savings notion, because in those days, of course the house, the
22 home, was a major source of retirement savings. There was depreciation. Today that's fundamentally
23 different as this depreciation in housing and more and more families have paid the high cost of higher
24 education by mortgaging the home so that the major source of funding is the home. It's gone away. And it
25 raises for me bigger issues about housing, and I'd be curious about what your discussion was.

1 When we think about Medicaid particularly, they'll pay room and board in nursing homes, but
2 virtually no place else. When you think about the deinstitutionalization of the DV population and others,
3 we haven't replaced it with any sort of meaningful policy going from a services and supports kind of policy
4 about housing. And I wondered what the Commission did around those topics about housing and where
5 we get those kinds of alternatives, because I don't think we could ever -- if we assume everybody's going to
6 continue to live in their own homes as elderly people or if we really think about meaningful community
7 based places for people with various disabilities, housing policy needs to be front and center, and I'm just
8 curious to know what you did on that.
9 DR. WARSHAWSKY: Yeah. Just to -- I know it came up in a different -- not exactly the way you
10 presented it, and I think that's a very helpful way of presenting it. But we -- it came up for us in a couple
11 different ways.
12 Number one is that it just -- it's just again, understanding what the Medicaid eligibility rules are and
13 the exclusion of the value of the home from the accountable assets. So again, we didn't finish that idea,
14 because we simply didn't have the time or the data, but it was clearly an important aspect of this problem.
15 So that's one way in which it came up.
16 The other way was -- and there was one Commission member who was very active on housing
17 matters in terms of her professional background. And it was a recommendation of the Commission in
18 terms of using the natural occurring communities and sort of leveraging that for a sort of efficiencies in the
19 provision of care. So that was, you know, a recommendation of the Commission.
20 But you know, you raise even yet another sort of nuance to that question, which is sort of
21 recognizing what has been going on in housing. And I would even add, you know, part of the genesis of
22 financial crisis was precisely where housing became, you know, a true asset and, you know, not just a -- you
23 know it was totally monetized, whether for good or for bad.

1 So you know, I mean I think those are, you know, the issues which you raise I think are very
2 valuable. And if we had more time and resources, that would have been good if we could have done that.
3 But we did, we certainly did recognize the topic.
4 DR. CHERNOF: I think Mark hit the nail on the head. You know, there was so little time for us
5 and so many topics to cover. And, you know, the eloquence that you just brought to that issue is a level of
6 complexity that, candidly, we didn't get to, but it is really important. I mean I think this notion of we are
7 still operating off of a -- not this room, but just collectively as a country -- we're operating off an
8 assumption set that is looking backward as opposed to looking forward.
9 And so this challenge of, you know, what has happened to the house as a nest egg, in Mark's
10 observation about how it got monetized and then what happened to that. The implications of that resource
11 for the life trajectory of the family, so for college, for elder care needs. The realities that families -- and then
12 that's back into my earlier comments, you know, the quality and shape of family structure will only become
13 more challenged, not less, over the next couple of decades, raises some really fundamental questions, and it
14 sort of circles us back to that point, right, which is doing nothing is the most expensive alternative we could
15 possibly have, because we're --
16 CHAIR ROWLAND: We do that pretty well.
17 (Laughter)
18 DR. CHERNOF: Well, what we have -- we have the, you know, the bills in the mail, and when it
19 finally hits our mailbox, right, is the Boomer's age through? Even if, again, we actually were very diligent in
20 the beginning of our work and, you know, disability rates have been declining.
21 But when you look at the number of older individuals who pass, who will pass through those
22 decades, just the sheer numbers will drive incredible need. And to your point, the resource that, you know,
23 may have been brought to the table you know eight or ten years ago, it's not the same.
24 CHAIR ROWLAND: (Inaudible).

1 COMMISSIONER HOYT: I'm interested in what their reaction has been to your work and the
2 report, or more specifically, who is upset --
3 (Laughter)
4 COMMISSIONER HOYT: -- what bothered them, why, either in the public meetings or since the
5 report came out.
6 DR. CHERNOF: I guess I'll start. So I -- the most interesting thing about -- Mark and I compared
7 notes about this. I think the most interesting thing about being in the seats that we sat in this summer, was
8 that, you know, people would come up to both of us from, you know, from all sides of the aisle let's say,
9 "You're not really going to get anything done." "Nobody really expects you to get anything done." And
10 actually, I think what we both observed over the summer is, that was the biggest fallacy, about particularly
11 where the aging and disability communities, delivery systems, I mean everybody who has an interest in this
12 space, were.
13 So in fact, everybody had incredibly high expectations, and that somehow that we would unite and
14 we would solve every problem under the sun. And so the disconnect between those early comments and
15 the realities of doing the work, I think we were -- both of us were kind of fascinating.
16 With respect to specific communities, you know, I -- so I think there are many places where folks
17 would have liked us to go further, and we did not feel that in the time available, given the level of discussion
18 we had and the amount of data that was available to us, that we could take certain points as far as some
19 individuals might like us to take them.
20 So I'll give you a specific example. Like readouts, like why not say, why not turn to you and say, you
21 know, "Home and community based services should be prioritized above nursing homes, institutional care,
22 period."
23 You know, I think that for the Commissioners, it's, you know, conceptually not that people were
24 against going that far in the recommendation as a concept, but understanding what that really meant, I mean
25 there were places where our work sort of felt kind of data-free to people. And you know, in a data-free

1 environment or something that felt like a data-free environment, we wanted to make sure we gave voice to
2 the concept as far as we could take it and to prove -- I mean I think one of the most important things was
3 for us to prove that conservative and progressive appointees could see the value and make the case for
4 getting community based services out in front, but not willing to get in front of all of you and say, "Well,
5 you know, you should fundamentally change the rules of Medicaid." Because I don't think that the
6 Commission, as a whole, felt that they had to do that to get there.
7 I think that there are folks that would have liked us to come forward with -- and you see this a little
8 bit in financing, right? There are folks who would have liked us to come forward with a full throated
9 financing solve that people were less than pleased that we couldn't accomplish that.
10 I'll just say, I think given another 90 days and given the identification of the group, we could have
11 made a lot more headway. But shy really good data and the kinds of cooperation that we would have
12 needed from the various branches of Government to kind of cost things out and really understand what
13 attachment points look like and the implications for the budgets that, you know, you guys provided us. We
14 may not even have been able to get there over 90 days. I'm not sure that this was the right 15
15 Commissioners to do that kind of work, because with the exception of Mark, you didn't have any other
16 Commissioners who were genuinely health economists, for example.
17 I mean, it was maybe a different set of skills that the Commission, as a whole, could have done on
18 its own and it would have needed a lot more horsepower underneath it to give a credible recommendation.
19 So you know, for those folks that were hoping that we would come forward with a big social
20 insurance program recommendation, you know, I think, you know, those folks would have liked to see
21 more. The disability community had one, obviously, we say sort of one and a half representatives. And
22 what I mean by that is there was one, really one fundamental voice for disability issues. The White House
23 replaced one of its seats that was vacant throughout the Commission right at the very end with another
24 disability representative.

1 And you know, were we able to dynamically address the needs of every community, the Alzheimer's
2 Community? Other communities have very specific needs underneath the umbrella of long-term services
3 and supports, no, I don't know that we went as far as everybody would have liked us to go.
4 I do think what we were able to do was take the concept as far as we could. And I think the most
5 important commitment for me was that, you know the Democratic and Republican Appointees could come
6 together, even in places where they were kind of uncomfortable, because sometimes the data felt a little
7 either lacking to us or just not available. And so to say, this is still the right principle, I mean people might
8 have a slightly different lens on what it means to get it right financially or what to get -- how to get it right
9 operationally.
10 But trying to be as broad as we could be was very important. So, Mark, you want to add anything?
11 DR. WARSHAWSKY: Really, just very briefly, you know, I think the Commission has some really
12 great recommendations, bottom line. And, you know, if they would -- if all the 28 recommendations were
13 actually put into place, it would be a great step forward. So, I'll just leave it at that.
14 COMMISSIONER MOORE: We have a requirement, of course, if any of our recommendations
15 are voted on individually with a recorded vote, and then are also costed out, the cost implications. Neither
16 of those were pieces of your requirements?
17 DR. CHERNOF: So with respect to the first question, the enabling law just said we had to have a
18 vote, and so we chose not to vote on individual recommendations. We chose to have -- the process that we
19 used -- I should probably spend a second and talk with you about the process, because I think it was
20 interesting and instructive.
21 We asked each Commissioner to present their five best ideas in writing in a semi-structured and
22 space-limited format. And they were provided to our staff, and Larry and the team then de-identified where
23 the idea came from, and then sorted them by sort of the three broad categories, and then within categories a
24 little bit, because there were -- as you would imagine, some of the ideas would be close to overlapping, and

1 we wanted to make sure we could collate ideas we could, which were service delivery, workforce and
2 finance.
3 And then we asked people to blindly vote on their top 10 of the roughly 70'ish ideas that were
4 generated. And then from that came -- we were able to build a grid that showed where there was broad
5 agreement. And Mark and I actually knew -- and staff knew, actually, whether there was broad agreement,
6 you know, that was bipartisan, sort of broad agreement that was sort of more leaning one direction or
7 another. But all of the ideas that got broad agreement, regardless of their lean, got a thorough discussion.
8 And the vast majority of those actually made it into the final report, which said something about the ability
9 of political appointees to come together around these ideas, which I think both is kind of interesting --
10 maybe it's the most interesting part of the work from a facilitation standpoint.
11 And I raised that because what we wanted to do was bring together a specific broad set of
12 recommendations. We didn't think we could operate the way you -- the way you do, given the very limited
13 time frame.
14 The other reason that we chose that strategy, quite candidly, is, you know, while the enabling
15 legislation suggested we were going to have all kinds of help and support, getting something scored in the
16 middle of the summer, given all the other things that were going on, you know, the practical realities of
17 engaging the various folks who, technically, on paper were available to support us was easier said than done.
18 And these aren't, you know, for those organizations, these are not simple questions. And I think to
19 actually frame a really good question that they could then cost out and how one goes about that, probably,
20 you know, a 90-day window, and that was not going to work. So we picked a voting strategy that was
21 appropriate for the kind of time and resources we had available.
22 COMMISSIONER CHECKETT: Could you say just a little bit more about the discussion and
23 maybe what's in the report or the appendix about the more uniform assessment process or tool, the process
24 for coming closer to that? Why you think maybe that has never happened?

1 DR. WARSHAWSKY: Well, actually, I will start, but really, Bruce, I know knows much more about
2 this. But I will give you the perspective of somebody who, where this was sort of new.
3 It struck me as so important and so essential to everything that, you know, all of our
4 recommendations really. And it was truly a true consensus item. There were people on the Commission,
5 Commission members who, you know, actually are in this business, and they run facilities, they run care
6 services, and they were so, you know, it was so important to them. And I took their lead, frankly, because,
7 you know, they run this thing and they provide the services.
8 But also under Bruce's tutelage in terms of understanding, this is -- where this, you know, where real
9 savings can occur, because it's sort of where the integration can occur. And so I mean, you know, I was sort
10 of -- and sort of in a way, amazingly it doesn't exist. So that's a perspective of somebody where this was,
11 you know, new.
12 DR. CHERNOF: And I think for the Commission, as a whole, I mean what was part of our -- and
13 really why I wanted Mark to go first here is, you know, we have a -- the Commission is this really robust
14 group of folks. People showed up. They, really hard, they read everything. People brought their own
15 experience to the table. And I think this was one of those sort of crystallizing moments with the
16 Commission, because for those folks who were in this space, this issue was just maddening to them, and
17 that's the politest word I can use.
18 And I think for those folks who come at this more broad -- from a broader policy perspective, like
19 Mark, the whole idea that you could operate these sorts of systems and programs without that kind of
20 information and content, to drive decision making, was shocking.
21 And so -- and I -- I will say it again. I would be remiss if I didn't highlight the fact that many, many
22 Commissioners were deeply, deeply frustrated that CMS has been at this for an incredibly long time. It's
23 not -- I get it's not necessarily the easiest thing to do and, you know, uniform assessment, you got two
24 words, and then what you build into that, you know, how big is it, what range of services. And so it can be

1 big or small, you can make it complicated. But the idea that it's been sort of limping along inside CMS now
2 for years, decades --
3 (Laughter)
4 DR. CHERNOF: -- is flatly unacceptable. And I think one of the things the Commission wanted
5 to make sure we gave voice to is it's not okay. It's not okay.
6 And as we actually see, you know, all of these new kind of programs being ruled out, so whether
7 you're thinking about, you know, Medicaid health homes or Medicare medical homes or dual-eligible pilots,
8 you know, all of these need uniform assessment, and they need to start with the person. It is not about the
9 payer source. They need to be useful to the various paying entities, but it really is about trying to capture the
10 needs of the individual.
11 And that's -- to the degree that there is a savings to their -- to the degree -- well, and I'll go back to
12 the -- I'll go back to maybe the block grant question for one more second. You know, I think what really
13 worries people for those, you know, and we've got a little bit of a window, but what really worries people is
14 that at the end of the day, you know, you're going to narrow funding in the face of exploding need.
15 And that, you know, once you start down that road, you can't -- you know, people won't, you know
16 -- unringing a bell is a very hard thing to do, and I think part of the problem is, without uniform assessment,
17 without adequate information to really build the most efficient plan of care, and then to roll that up into a
18 population, to start to be able to talk about outcomes, are we actually paying for -- investing in outcomes
19 and the outcomes in people's lives? We are sort of flying blind.
20 So I'll sort of stop. I'm sure that feels a little preachy, but I mean this was one of those
21 recommendations where you could not have found more support across the entire range of kind of people
22 and experiences.
23 CHAIR ROWLAND: Thank you so much for coming. We certainly enjoyed your experiences as
24 Commissioners running a commission, as --
25 (Laughter)

1 CHAIR ROWLAND: -- we have also struggled to come up and get focused on. But, fortunately,
2 we didn't have your short time frame or I don't know where we would be.
3 But you know, one of the programs that has been suggested, Anderson Pilots, and all types of
4 demos on through the years as a solution for the caregiver problem, has been what's usually called or
5 referred to as, "Consumer Directed Care," where a consumer who is, him or herself, disabled or a senior, is
6 going to be able to pay a caregiver, often a family member, and be reimbursed for their care and -- or to be
7 able to reimburse them to come in and take care of them.
8 And that's -- you've seen a lot of discussion for years about that and Medicaid, but when you look at
9 the Medicaid experience, there has been extremely low outtake, so maybe in a state there might be two or
10 three thousand people who have done that, if that many, out of you know hundreds of thousands of people
11 potentially eligible.
12 So it fascinates me, because it's gotten a ton of attention, but it's never really materialized
13 particularly. I'm just wondering if you all talked about that, looked at that, heard about that, and, you know,
14 my role is Medicaid, so I'm guessing that that's going to be in a larger context that that could come up with
15 or anything when you considered? You're looking really puzzled, so I'm thinking not.
16 (Laughter)
17 DR. WARSHAWSKY: Well, I'm not so much puzzled. I'm trying to remember where it came up.
18 It certainly did come up and I believe it was based on testimonies of -- we did hear from Medicaid folks and
19 we also heard from -- I believe it also came up in the context of Veterans, right?
20 So it did come up. I will be candid, that it wasn't a central item. I think Bruce has a better
21 explanation.
22 DR. CHERNOF: No, I think Mark hit the nail on the head. And you know, I think a couple things
23 are true. We did actually hear -- we did actually hear a little bit about this in our public testimony, and in the
24 context of larger more thoughtful systems. I mean it kind of gets at the question of, "What's the right

1 resource for the right individual?" And that you know kind of this larger belief structure. And let me take
2 us off course for one second.

3 Let me look at how to care -- other kinds of work, generally, not just in Medicaid, that sometimes if
4 we just listen to folks really carefully and sort of capture that engagement with the individual in the family,
5 you actually get to a much better -- clinical decisions that also happen to be more costly. So it fits in that
6 larger group.

7 DR. WARSHAWSKY: Right.

8 DR. CHERNOF: I think for the Commission, you know, that was sort of what the value of
9 consumer-directed care was discussed and is part of the recommendations. We didn't quite get down to
10 that payment level you're describing. I think so maybe that's probably the best way to answer your question
11 and stop.

12 It's just -- you know, acknowledge it as an important piece of the care, acknowledge it as part of the
13 workforce. You could find it in the recommendation. We just -- and it wasn't that it wasn't necessarily of
14 interest to the Commission. We just didn't get to that payment question.

15 COMMISSIONER CHECKETT: And I appreciate that and I actually pointed out I think for a
16 larger discussion is we all wrestle with this very important challenge, because it is something that there --
17 especially in the Medicaid world, there's just been, you know, for years and years, you have to do this, this is
18 a great thing, this is what people want. But when you really look at the numbers, it doesn't support it, and I
19 don't know that that necessarily means that it isn't a great thing. So I just put it out there for us to not lose
20 sight of.

21 Thank you.

22 CHAIR ROWLAND: Well, thank you very much for coming, for doing the work you've done, for
23 being able to produce a report in 90 days to make us feel like we really need to set some higher time limits.

24 (Laughter)

1 CHAIR ROWLAND: But also for giving us a series of issues and ideas that we can pursue like a
2 uniform assessment as we go forward to make our recommendations, and we will be taking on long-term
3 services and supports as one of the issues that this Commission really needs to deal with.
4 And so we appreciate you both taking the time to come and share with us today, but especially the
5 time that you devoted to putting together this report.
6 And congratulations, not only to you, but to the staff that helped you put it together. Because we all
7 know that we're only as good as the staff. So thank you.
8 DR. CHERNOF: Okay. I just want to say, on behalf of both of us, and on behalf of all the
9 Commissioners, we thank you for taking the time to hear this.
10 I think one of our fears was that we would develop a document that would just sort of sit on the
11 shelf. And the fact that you guys have invited both of us just means the world to us.
12 And I think I would just say since many of you have interactions with the other Commissioners, all
13 the Commissioners are really dedicated to this report.
14 So while Mark and I are here, I mean the rest of the folks, I think in their own right,
15 feel just as strongly that the dialogue needs to continue. So I would just encourage you to do that. We look
16 forward to the actions you take. And if we can give help, individually or collectively, in the future, let us
17 know.
18 CHAIR ROWLAND: Great. Thank you very much. Thanks. All right. We're going to take about
19 a 10-minute break, and then reconvene to go back to (inaudible). Thank you.
20 CHAIR ROWLAND: Chris.
21 **### SESSION 4: Short- and Long-Term Issues for CHIP**
22 * MR. PETERSON: Thank you Diane. In September we came to you with a long list of
23 possible CHIP issues, ones you wanted us to bring back to you for your continued consideration.
24 So based on your feedback we provided you in your Commissioner materials in Tab 5 papers that I
25 am going to summarize here today on three CHIP issues: CHIP waiting periods and their impact on

1 churning; CHIP premiums including premium stacking with exchange coverage; and then on the long-term
2 future of CHIP.
3 We look forward to your feedback on the particular options we are bringing to you today. And any
4 options you would like to proceed on we will submit them to the Congressional Budget Office and will
5 work on the wording of possible options and bring that back to you at our December meeting with
6 additional rationale and consideration of the pros and cons.
7 So what I am going to do is go through the issue of CHIP waiting periods. Talk to you about some
8 potential options that were in your materials and have them on the slide. And then I am going to stop and
9 we are going to have some discussion at that point.
10 Then we will do the same with CHIP premiums and I will stop at the slide that has the options on it
11 for you to discuss.
12 And then finally on the long-term future of CHIP.
13 So in terms of background on CHIP waiting periods this was talked about this morning. CHIP was
14 designed in particular to be different from Medicaid in many ways. One of the key issues that the Congress
15 was worried about in 1997 was trying to prevent crowd-out, that is to say they didn't want people to get
16 onto publically subsidized coverage and give up their private coverage.
17 So CHIP has many levers to try to accomplish that; one of which is that children must be uninsured
18 to enroll. But in addition states have flexibility in separate CHIP programs to require that children be
19 uninsured for certain amount of time before enrolling.
20 In January 2013, 37 states had a CHIP waiting period. And they ranged from one to 12 months.
21 And we have talked with some experts and reached out to many states one by one. And found out that 18
22 of those states are, in fact, eliminating their CHIP waiting periods by 2014.
23 So I think that goes to the issue that was talked about this morning about what role do CHIP
24 waiting periods have in the presence of exchange coverage and the interactions.

1 It is also worth noting that there were new federal regulations in July. We have talked about them
2 before but I want to reiterate them again that they limited CHIP waiting periods to no more than 90 days.
3 And then even though states have numerous of their own exemptions from waiting periods the federal
4 government included in the new regulations a long list. And you see them there. I am not going to read
5 through them.
6 But some of them are kind of what states have used for a long time like if the parent dies and the
7 child loses coverage because of that. But then you also see some of them are kind of related to the
8 affordability test and exchange coverage. So you can see where that interaction comes to play.
9 So let's talk about those interactions. During that CHIP waiting period children may be eligible for
10 subsidized exchange coverage. How individual states who have state based exchanges are working that out
11 is another one of those situations where it varies by state.
12 But I want to talk today about what we do know in terms of the Federally Facilitated Exchange or
13 FFE and some folks call it the Marketplace. The FFE will not make CHIP determinations where there is a
14 CHIP waiting period. If the state has chosen to have a CHIP waiting period, the FFE cannot, will not
15 make those determinations.
16 Instead when a family comes in and it appears the child is eligible, if they are in that CHIP income
17 range, that application must be transferred to the CHIP program. If a waiting period applies, so in other
18 words the applications come to CHIP because it looks like you are eligible for CHIP and then the state says
19 no you are subject to a waiting period, then that information must be transferred back to the FFE. Then
20 the child may be enrolled in an exchange plan.
21 The parents will then have to choose a plan for them; go through that exchange process. So there
22 could be cases where even if the child is eligible for that exchange coverage maybe they will not be enrolled.
23 Once the waiting period is satisfied which now is 90 days or less for CHIP --
24 COMMISSIONER ROSENBAUM: May I ask you a technical question here. If you can enroll
25 because I do not understand this -- if you can enroll in an exchange plan during this so-called CHIP waiting

1 period, how do you ever satisfy the waiting period? I thought that the waiting period is that you have a
2 period of time without coverage.
3 MR. PETERSON: It is a little bit tantological; isn't it?
4 (Laughter.)
5 COMMISSIONER ROSENBAUM: We used to call that a Catch 22.
6 MR. PETERSON: Yes. Right.
7 COMMISSIONER ROSENBAUM: By definition they have essentially overridden the waiting
8 period.
9 MR. PETERSON: Yes.
10 COMMISSIONER ROSENBAUM: Okay.
11 MR. PETERSON: I mean I think another way to think of it is that the waiting periods are primarily
12 about ESI.
13 COMMISSIONER ROSENBAUM: Uh-huh.
14 MR. PETERSON: So in other words a person could have come directly from Medicaid to CHIP --
15 COMMISSIONER ROSENBAUM: So it is only ESI anybody is concerned about.
16 MR. PETERSON: So really we are talking about the purpose here was voluntary droppage if you
17 will of ESI.
18 So where was I, let's see here. So once the waiting period is satisfied then CHIP agencies are
19 supposed to have what CMS calls a smooth transition onto CHIP.
20 And then, of course, once the child is to be enrolled in CHIP, they have got to disenroll from that
21 exchange coverage. So there has to be a hand-off between the plans, et cetera, et cetera.
22 So one of the questions we wondered was okay, if we look at typical CHIP kids at a point in time.
23 So let's say we look at them in the CHIP income range in December, what was their insurance status three
24 months ago, ninety days beforehand. And you see here on this slide that 82% were uninsured; 12% were on
25 Medicaid and 5% were on ESI; so a relatively small number of children potentially.

1 Unfortunately we don't have any data that shows us how much crowd-out was prevented by waiting
2 periods. And that is one of the problems we often have with anything that is preventive is it is hard to
3 assess how much was really prevented. But this just tries to give some sense of the order of magnitude.
4 So in response to many of the comments that CMS received on the CHIP waiting periods,
5 commenters -- many commenters called for CMS to get rid of the CHIP waiting periods altogether. They
6 said that it places an administrative burden and complexity on CHIP agencies and exchanges; it hinders
7 streamlined coordinated enrollment; causes churning which we have talked about and I have tried to
8 illustrate in the example; disruptions in continuity of care. And also that there is a lack of evidence of
9 crowd-out; in particular that CHIP waiting periods are helpful in that regard.
10 CMS acknowledged the concerns but left the state flexibility intact noting that there are many new
11 federal exemptions.
12 One of the panelists this morning noted that one of the reasons they got rid of their CHIP waiting
13 period was because the federal exemptions were so numerous that they thought there just weren't hardly
14 even enough children to merit maintaining that waiting period.
15 And CMS noted that states will have to assess whether the perceived benefits of that waiting period
16 are greater than the administrative and system capabilities that states have.
17 CMS also recognized what they called a robust but inconclusive evidence base on the prevalence of
18 crowd-out.
19 (Laughter.)
20 COMMISSIONER ROSENBAUM: It is a lot but it doesn't tell you anything.
21 COMMISSIONER CARTE: Well some states have data and some have none on crowd-out.
22 COMMISSIONER ROSENBAUM: But you can't conclude anything from it.
23 CHAIR ROWLAND: -- availability of public coverage will cause people to not take up employer
24 based coverage or shift from employer based coverage to public --
25 COMMISSIONER MOORE: Public coverage will crowd-out other kinds of insurance.

1 COMMISSIONER WALDREN: But does robust mean there is lots of data for --

2 COMMISSIONER ROSENBAUM: That is what I was asking.

3 MR. PETERSON: Yes. I think the point is that they're --

4 COMMISSIONER ROSENBAUM: That is why I think we should ignore it.

5 MR. PETERSON: I think there has been a lot of research and it comes out in many different ways.
6 And so it is hard to conclude anything. I mean people -- smart researchers have applied many different
7 methods to try to come up with estimates. And those estimates vary a lot. So it is not for a lack of effort
8 let's say by the researchers.

9 CHAIR ROWLAND: Chris did CMS have the statutory authority to just outright eliminate waiting
10 periods or could they only reduce them and leave it at state option?

11 MR. PETERSON: This is probably one I should hedge on and say I am not sure. I will say there is
12 nothing in the statute that says that states must have a waiting period or that it is -- yes, I am going to leave
13 it at that. But all that is required in the statute is that states use methods to prevent crowd-out. And so this
14 is one.

15 Now if CMS decided to get rid of it, there are others available. And one could contend that the fact
16 that states are monitoring how many kids have employer sponsored coverage. So there are many things that
17 states in their CHIP state plans are doing now that counts as trying to prevent crowd-out.

18 CHAIR ROWLAND: So we could say that in light of all of the changes going on in the health care
19 system that this particular strategy to avoid crowd-out is not a particularly prudent one and should not be
20 retained because it is an administrative nightmare maybe.

21 MR. PETERSON: Sara.

22 COMMISSIONER ROSENBAUM: I had it on. I don't know what happened. I do think it is
23 notable that in the preamble as I recall CMS did not say it lacked the legal authority to take the step. What it
24 said was that the evidence was essentially inconclusive and this is something that states should decide. And

1 so that led me to assume that they had decided that it was a step that they could take if they wanted to;

2 chose not to take it.

3 But I like Chris am sort of uncertain but that is how I would interpret what we saw in the rule.

4 VICE CHAIR SUNDWALL: Question. In Utah we went, when I was a Commissioner of Health,

5 to open enrollment for CHIP, no more periods where you could sign up; it was available all year. Does that

6 mean they would not have a waiting list or could they still have a waiting list if there were open-enrollment?

7 MR. PETERSON: Yes, I am not sure about that. I would have to look into the Utah specifics. I

8 don't know that policy in particular. So I would want to --

9 VICE CHAIR SUNDWALL: Well anyhow it seemed very progressive thing for a conservative state

10 to do but they went to open-enrollment which got a lot of accolades from the advocates.

11 CHAIR ROWLAND: But a waiting period and a waiting list are two different things.

12 VICE CHAIR SUNDWALL: Or waiting period; that is what I meant.

13 CHAIR ROWLAND: The waiting period is on the individual.

14 VICE CHAIR SUNDWALL: So you could still have open-enrollment but have a waiting period? I

15 was just curious.

16 MR. PETERSON: Yes, generally speaking for CHIP if a child is eligible they can be enrolled --

17 VICE CHAIR SUNDWALL: Yes.

18 MR. PETERSON: -- notwithstanding some waiting period like we are talking about.

19 VICE CHAIR SUNDWALL: Yes, that is what I thought.

20 MR. PETERSON: Okay.

21 COMMISSIONER RILEY: I am reminded -- this is like going back in history but what are the

22 requirements around crowd-out and how does CMS enforce that? Because I think crowd-out doesn’t make

23 sense anymore. But if it is going to exist, I guess it could, you would want to continue to have ESI. So if

24 you want to continue to have ESI and continue to have a crowd-out rule

25 COMMISSIONER ROSENBAUM: (Inaudible). That is --

1 COMMISSIONER RILEY: Right. So what are the -- how does CMS conduct oversight of crowd-
2 out? And might this be the easiest way for states to respond. Before we leap to a conclusion I am trying to
3 think through if crowd-out is still a strong enforceable activity of CMS, what other tools do states have in
4 general?

5 COMMISSIONER CARTE: Every year states have to explain in their CHIP annual report what
6 measures they take for substitution prevention, prevention of substitution, crowd-out. And the easiest thing
7 to do is say that you have a robust waiting period or you have a premium. And I don't -- I know in our state
8 we did not have any available data.

9 And also because ultimately the real issue about whether or not the family dropped insurance was
10 mostly related to affordability or one of the exceptions. It always seemed a really pointless exercise for me.

11 MR. PETERSON: So to your point Trish what Sharon just mentioned is the Annual CHIP
12 Reporting and this is from the report and it is a template. And there is a section on substitution of
13 coverage, crowd-out. First question is: do you have substitution prevention policies in place? Yes. And if
14 yes, then there are four things you can choose. You choose a waiting period between terminating private
15 coverage and enrolling in CHIP. You impose cost sharing in approximation to the cost of private coverage.
16 You monitor health insurance status at the time of application. And then other, please explain.

17 COMMISSIONER MOORE: Some people did surveys. I mean they said they did random surveys.
18 I don't know whether they did. But they said that.

19 COMMISSIONER ROSENBAUM: I mean under the ACA the policy now is that when you go
20 into the Marketplace you just indicate that you don't have ESI and that is all there is to it. You don't have
21 ESI you can come into the Marketplace.

22 COMMISSIONER CARTE: Well one other significant activity even though it was post-enrollment
23 we had -- we have a contract whereby we monitor the presence of other insurance within 30 days post-
24 enrollment.

1 And actually if we had a concern about crowd-out it was usually the public employees who were
2 sometimes coming -- trying to come into CHIP. So that was probably the most effective monitoring. And
3 painful because you obviously had somebody sign up and then you would send them a letter asking them
4 did they have a change in circumstance or something or a letter from their employer showing that they just
5 recently dropped or something like that. But otherwise I feel like it was being effectively monitored.
6 MR. PETERSON: So the -- in light of that background then the options that we are bringing to
7 you are A. Congress should eliminate CHIP waiting periods. B. is Congress should eliminate CHIP waiting
8 periods were parents have subsidized exchange coverage. So the difference on B. is, of course, this is only
9 for those children where the parents have subsidized exchange coverage. The idea being as Sara just
10 mentioned for exchange coverage there already is a crowd-out provision that is a fairly high bar. And that is
11 you essentially cannot have an offer of employer sponsored coverage. And so if the parents have subsidized
12 exchange coverage that means they have already met some fairly significant crowd-out test. So if you really
13 are worried about crowd-out then B. could help with that. And then C. is like A. except it says states should
14 eliminate CHIP waiting periods. That is to say rather than A. making a recommendation to the Congress
15 that would then make a statutory change that is mandatory upon all states, the Commission could say, states,
16 this is something that we recommend you do.
17 So at this point I will stop for your discussion.
18 CHAIR ROWLAND: Could you review for us again how many states have moved to eliminate the
19 waiting period come January?
20 MR. PETERSON: In January 2013 there were 37 states that had waiting periods and about half of
21 those are eliminating it by January 1, 2014. So --
22 CHAIR ROWLAND: So the states are already moving, many of them, to eliminate it?
23 MR. PETERSON: That is right.

1 CHAIR ROWLAND: And when we look at the administrative burden and the complexity which
2 are two of our criteria we ought to consider those as we look at the options too in how to make the
3 program simpler --
4 COMMISSIONER CARTE: The other thing I would add to that is to look at the waiting period
5 exemptions which I would say families might not have known if they had applied in the past and received a
6 denial but now if they enter through the exchange and find out they are Medicaid eligible that will be made
7 known to them if their current cost of insurance exceeds the affordability threshold.
8 CHAIR ROWLAND: We know if any of the exchanges would be monitoring whether they have
9 fulfilled a waiting period requirement or just enrolling them if they appear eligible for CHIP?
10 MR. PETERSON: The onus is on the CHIP agency.
11 CHAIR ROWLAND: Okay. They can just refer to -- Sara?
12 COMMISSIONER ROSENBAUM: To be clear on the difference between one and two; the option
13 one, option two; or A. and B. up there I guess. So under Option A. if the parent had affordable ESI but
14 there was no affordable dependent coverage, choosing -- our going with A. would allow the parent to
15 immediately take advantage of CHIP for the child and sort of as a way of offsetting the problem with the
16 affordability test for the subsidies in the exchange.
17 Whereas under Option B. up there, Option 2 on our sheet the ability to take advantage of CHIP
18 immediately without a waiting period would be confined to parents who were themselves getting their own
19 coverage through the exchange. That is they had no crowd-out issues; whereas under Option A. the parent
20 could well be an ESI. That is the difference between A. and B. I just want to be sure we see the difference
21 in scope. Okay.
22 CHAIR ROWLAND: I also want -- we have these worded as Congress should. And I think a
23 critical issue here is can a recommendation be made that the Secretary should because it may not require a
24 statutory change. So I think to distinguish between an administrative action and a statutory action.
25 Okay. I have Steve, Andy, Robin and Mark.

1 COMMISSIONER WALDREN: So if we go with A. there is still the provision for crowd-out. So
2 a state is going to have to figure out how to handle that. Except we have eliminated the option for them to
3 use a waiting period. And if that is the case, then how many of those that have a waiting period that as of
4 yet we don't think are going to change have some type of premium as the way that they are dealing with the
5 crowd-out. Because my concern would be if we eliminate the waiting period then the only option they are
6 going to have is to increase the premium in some way.
7 MR. PETERSON: Or there are other things that they can do including monitoring health insurance
8 status at the time of application is one of the things that apparently CMS counts as having an adequate
9 crowd-out policy in place.
10 COMMISSIONER WALDREN: I guess I get that as an option but do we think states will take that
11 option. It seems like it is easy to either -- if you want to checkmark the box relative to that and say you are
12 compliant, is to have a waiting period or to have some type of premium system. The other ones are like
13 other or you have to kind of be proactive. My concern would be that most states that would have been
14 proactive to take one of those two other options have likely already taken those other two options. But you
15 are right, that is an option and they may do that.
16 CHAIR ROWLAND: Do states have the option of making the waiting period five days?
17 MR. PETERSON: I believe so. There is a state that has a one month waiting period. I think there
18 are multiple.
19 CHAIR ROWLAND: Okay.
20 MR. PETERSON: There is one state that has a one month waiting period.
21 CHAIR ROWLAND: Next I have (inaudible).
22 COMMISSIONER COHEN: You will stop me if I am saying something that doesn't make sense
23 please. So A. as Sara viewed is a blanket elimination of CHIP waiting periods and B. is a conditional
24 elimination for those families where the parents have subsidized exchange coverage.

1 I am worried at this stage that we don't know how much take up there is going to be. We don't
2 know a lot of things. And I am wondering about sort of both the equity and the policy of limiting that
3 exception.
4 While I am hesitant about the blanket exception in terms of like what evidence we have now that
5 was different in the past.
6 On B. I am worried that it is under-inclusive because there will be children whose parents may be
7 eligible for the coverage. And so I am wondering if we could consider another option or a tweak on this
8 option which is that Congress or whomever we are going to direct this to should eliminate CHIP waiting
9 periods where we could say the parents or we could say the children under federal law would be eligible for
10 subsidized exchange coverage.
11 So the idea being in some cases where even if the parents have either elected to face a penalty rather
12 than enroll and/or are eligible for an exemption because of the affordability issues or other things that we
13 not penalize the children from being able to more immediately access CHIP.
14 MR. PETERSON: And I would only comment on two things. One is about the trade off of the
15 blanket statement versus complexity.
16 COMMISSIONER COHEN: I realize I am moving in the wrong direction on that.
17 MR. PETERSON: And point number two is that if you look on slide four that lists the exemptions
18 that are now required federally that that may to some extent satisfy those concerns about the affordability of
19 the parents' coverage and may be somewhat of a proxy of individuals who would be affected by what some
20 are calling the family glitch.
21 COMMISSIONER ROSENBAUM: We are already so filled with exemptions and exceptions and
22 provisos when you can overcome the waiting period --
23 COMMISSIONER COHEN: Yes.
24 COMMISSIONER ROSENBAUM: -- and we already have so many moving parts in terms of
25 where the parents are going to end up. And given the problem of the affordability barrier to the coverage is

1 the other thing I don't quite understand how the child -- we know the child can get into the exchange. And
2 it seems to me given the weakness of the evidence regarding the effectiveness of a waiting period and the
3 fact that in the Marketplace we have moved to a very simple test, you just verify that you don't have an offer
4 of affordable coverage. Then why would we keep the provision for any population of children? It just
5 seems to me that the clean thing to do given how much the whole current policy is pockmarked and it is so
6 hard to follow. Simplicity here I think is better.
7 MR. PETERSON: And the other point that I would make is currently the FFE cannot do any of
8 these determinations. But if the FFE has actually already found out that the parents, they've clicked they're
9 enrolling in subsidized exchange coverage, then this could be a case then where the FFE could say, okay,
10 they have already met this task. All this other waiting period stuff goes away because this criteria has been
11 met.
12 The other thing is Diane with respect to your point about that this could be an administrative
13 recommendation and that is then what that would be is adding to this list on Slide 4 essentially another thing
14 in the federal regulations about what is an exemption to the CHIP waiting periods.
15 COMMISSIONER SMITH: I am also confused about the wording of Number 2 and it says that
16 they already -- I mean basically it says that they have enrolled in subsidized exchange coverage, the parents.
17 Does that mean they didn't enroll their child or they have a newborn or a newly adopted child and now they
18 have to enroll them in something? Or did they just not enroll their --
19 MR. PETERSON: So just recall that parents don't have a choice about whether they are going to
20 enroll their child in CHIP or exchange coverage. Medicaid trumps CHIP.
21 COMMISSIONER SMITH: Right.
22 MR. PETERSON: And CHIP trumps exchange coverage. So when this family comes in if the
23 child is in that CHIP income eligibility range --
24 COMMISSIONER SMITH: Uh-huh.
25 MR. PETERSON: -- that child is supposed to be enrolled in CHIP.

1 COMMISSIONER SMITH: CHIP and not in the exchange even if the parents qualify for the
2 exchange --
3 MR. PETERSON: Right.
4 COMMISSIONER SMITH: -- with subsidies.
5 MR. PETERSON: But in the case of the waiting period then everything gets --
6 COMMISSIONER SMITH: So wouldn't they all get enrolled at the same time and we are saying
7 that they are -- maybe I am tired. I don't know. I am saying that they are -- it says parents enrolled -- with
8 parents enrolled in subsidized exchange coverage. So to me the first thing happens and then the second
9 thing happens. Wouldn't they get enrolled at the same time, the parents in the exchange and the child in
10 CHIP if they are all doing it together?
11 MR. PETERSON: If B. were put into place?
12 COMMISSIONER SMITH: Right.
13 MR. PETERSON: Yes. I think that would be the idea that the parents would enroll in the
14 subsidized exchange coverage and then the FFE this example could say you parents are in subsidized
15 exchange coverage. Generally we could not just enroll your child in CHIP because there is a waiting period
16 in this state. But because you are enrolling in subsidized exchange coverage and have met the crowd-out
17 conditions for exchange coverage then yes, the child could then be enrolled in CHIP without a waiting
18 period.
19 COMMISSIONER SMITH: But the parents have to be --
20 MR. PETERSON: Correct.
21 COMMISSIONER SMITH: -- in the exchange first?
22 MR. PETERSON: Yes.
23 COMMISSIONER SMITH: And the child breaks their leg.
24 COMMISSIONER HOYT: The arguments around administrative simplicity really resonate with
25 me. That would be enough to do it right there.

1 It also feels like a real mixed message to mandate the people have insurance and then in some states
2 enforce a waiting period and make them not do it even though mandates trump waiting periods to me.
3 COMMISSIONER RILEY: It seems to me it is almost which issue should we deal with first
4 because as we deal with our later recommendations about what shift should be we answer this question or
5 we could answer this question. So it is kind of cart and horse stuff.
6 The real problem it seems to me is crowd-out, is the provision in the requirements for crowd-out in
7 a new world. But the fact -- I mean we have to think about the fact that exchange coverage, if you have to
8 go to CHIP there is a crowd-out at both levels effectively.
9 So it seems to me this is emblematic of the bigger issue we have to solve and solving just this one
10 doesn't make a lot of sense to me. But if we are going to solve it I think that maybe two makes the most
11 sense. Although it seems to me there is a bigger fix here.
12 EXECUTIVE DIRECTOR SCHWARTZ: There is the timing issue, too, Trish, because this is
13 both a short term and a long term issue.
14 COMMISSIONER RILEY: Yes. I know.
15 EXECUTIVE DIRECTOR SCHWARTZ: Whereas the other things we were talking about earlier I
16 think there was acknowledgement that we are not close to that yet.
17 COMMISSIONER RILEY: Yes. Yes. So I think we may be safest with B but --
18 COMMISSIONER HENNING: I think especially in those states that have FFEs running their
19 exchanges rather than State based exchanges that Option 1 is going to be the one that makes it the easiest
20 for families to get coverage and to stay covered and to not have periods of un-insurance.
21 So of all those three options that we have looking at the families and the people, the beneficiaries,
22 regardless of anybody else plus the fact that it is much more administratively simple I would definitely go
23 with Option 1.

1 VICE CHAIR SUNDWALL: Just -- I guess I am in the queue. I have a related thing I think to
2 what I guess Chris was saying. I could be supportive I like, along with Mark, administrative simplification is
3 a good argument.
4 But related to this is our discussion earlier this morning about why can't they use federal dollars to
5 buy private insurance instead of CHIP. Because it just seems to me if the parents are going to enroll what is
6 there in the law that says you must have CHIP if you're entitled? Why couldn't they use their CHIP dollars
7 to get them in the family plan? I mean I think parents do want their kids in their plan if they can; don't
8 they? It seems related to this issue.
9 MR. PETERSON: I think what you are talking about is the idea that Arkansas for example is using
10 Medicaid funds to purchase exchange coverage. So it is premium assistance. And what you are suggesting
11 is a comparable thing for CHIP. And I think that that may -- I don't recall seeing any particular discussion
12 on this with respect to CHIP. But it seems to me if it is possible for Medicaid, it may be possible for CHIP
13 to do the same thing.
14 COMMISSIONER CHECKETT: So I want to -- my recommendations on this will be shaped in
15 some ways by ease. So what would be helpful for me to know, Chris, if you or Sarah or someone, does the
16 Secretary have the authority to make these decisions in and of his or her self because that to me makes it
17 much easier than getting to Congress and having the recommendation that Congress do something in and
18 of itself perhaps an oxymoron.
19 (Laughter.)
20 COMMISSIONER CHECKETT: But I am really serious because I think we should really consider
21 that. And do you know, Chris, or Sara, anybody?
22 MR. PETERSON: Well I think it just goes back to the earlier conversation that we had and that is
23 the Secretary had the opportunity to do this. They got numerous -- they received numerous comments.
24 People saying get rid of this. This makes no sense.
25 MS. CHECKETT: Right. That is right.

1 MR. PETERSON: They opted not -- the Secretary opted not to do that. She did not explicitly say
2 we don't have the authority to do this. And we could have provided one of those comment letters to say
3 that there should not be CHIP waiting periods.
4 COMMISSIONER CHECKETT: Right.
5 MR. PETERSON: So would a recommendation have more weight or is it better to take an
6 approach of the Secretary went down this path, did not take the path of getting rid of these and so
7 something else is required.
8 COMMISSIONER CHECKETT: Okay. I guess --
9 CHAIR ROWLAND: I think getting to Donna's point if we make a recommendation we want it to
10 be actionable. And if there is the authority to tell the Secretary that we feel they should have gone farther in
11 their reg, which they have the right to do then that is probably a little more actionable than proposing that
12 we send this up as a congressional bill.
13 COMMISSIONER CHECKETT: And just one more question. And again this may need some
14 more research because I don't know if it is germane or not but under Medicaid there is a premium assistance
15 program. It exists. It has been around for decades. Right.
16 And I don't think there is such a thing for CHIP. And so I don't know if that addresses the idea, the
17 thought about allowing people to use CHIP dollars to purchase on the exchange. You could probably do it
18 through an 1115 waiver. Certainly a really interesting -- certainly an interesting idea. Right. Well, I don't
19 know. I am going to stop. I have another question but I need to formulate it better. Thank you for
20 humoring my thoughts.
21 MR. EDELSTEIN: As we try to get clarity on the scope of this problem relative to simplicity
22 versus protection of federal dollars your slide 6 suggests that only 5% of kids in this income bracket are
23 likely to have had ESI. So this is the total percent of the population of kids that we are concerned about; is
24 that right?
25 MR. PETERSON: (Inaudible.)

1 MR. EDELSTEIN: Right. And then as Sara mentioned when you list the exemptions that's I think
2 Sara's word was pockmarked with all kinds of exemptions. So any idea of what percentage of kids we are
3 talking about? Is it somewhere under 1% of kids that we are talking about altogether once you take out all
4 the exempted groups? I mean are we talking about anything at all?
5 (Laughter.)
6 COMMISSIONER CARTE: Well it is late in the day.
7 COMMISSIONER RILEY: (Inaudible). But that is uninsured kids. The issue of crowd-out, it is
8 not just uninsured kids. Isn't the issue of crowd-out is people who are going to drop.
9 MR. EDELSTEIN: Well that was the other half of my question. So how concerned are we, not
10 just with whatever portion that 5% is truly under consideration here. But the 1997 question is that still on
11 the table? Are we still concerned about crowd-out from employers?
12 MR. PETERSON: And in particular waiting periods as a vehicle to prevent it.
13 MR. EDELSTEIN: So we just don't know; is that right? From the various crowd-out studies we
14 just don't know what would happen were there not protections against it.
15 MR. PETERSON: Robust but inconclusive I think is the --
16 (Laughter.)
17 COMMISSIONER RILEY: So in other words if we eliminate the waiting period millions of
18 families with incomes below 300 or 200% of poverty will just drop their coverage for their kids to come in?
19 CHAIR ROWLAND: But in essence we have eliminated any kind of a waiting period under the
20 new Medicaid provision so that anyone -- you don't have to prove that you were uninsured; you just have to
21 prove what your income is to get onto Medicaid. So it is a different standard now that we are holding for
22 CHIP.
23 MR. PETERSON: And also Sara's point, that is also true for exchange coverage. There is no
24 waiting period for either one.

1 COMMISSIONER ROSENBAUM: (Inaudible) and boom you are done. I mean that -- and of
2 course the irony here is that we are using CHIP precisely to overcome the fact that it is not that easy for
3 children in households where the parent has an affordable offer but the dependent coverage is not
4 affordable and yet the family is barred from getting subsidies. So to the extent that a strong rationale for
5 continuing CHIP financing is to offset the effects of the affordability test, it seems to me that following that
6 logic we want to bring CHIP into line with what in the absence of the affordability test would be the policy
7 for children which is you would just show that there is no current offer and you would be done.
8 COMMISSIONER CHAMBERS: Can you go to the option slide again, Chris. So in B. absent any
9 change come January next year parents could be eligible for the exchange but a child might have a waiting
10 period and not be in CHIP. Can the parents enroll the child in the subsidized exchange coverage during the
11 waiting period?
12 MR. PETERSON: Yes.
13 COMMISSIONER CHAMBERS: That is what you were saying.
14 MR. PETERSON: Yes.
15 COMMISSIONER CHAMBERS: And then you don't have a waiting period anymore because --
16 COMMISSIONER ROSENBAUM: But you can't if, in fact, you don't pass the affordability test as
17 the parent. If you have ESI yourself what you can't do is turn to the Marketplace for affordable coverage
18 for your child because affordability is determined by self-only coverage. So today the family can turn to
19 CHIP; but there is this strange waiting period; and, of course, if the child can't bridge with the exchange
20 coverage because the child is barred from the exchange coverage because of the affordability test. So
21 children are caught coming and going here. They can't get the exchange subsidy they should because of
22 affordability tied to self-only. And they can't get the CHIP because in many states there is still a waiting
23 period.
24 Since we have gotten rid of the notion of waiting periods as a way of dealing with crowd-out at least
25 where the exchange is concerned, then if we are using CHIP to overcome the affordability problem that we

1 now have created over on this side, then it seems to me we would bring the two into line on waiting period
2 policy.
3 MR. PETERSON: And the context for this recommendation really is not only that children may be
4 uninsured but it is also the Commission's emphasis on in 2014 churning that takes place within the year that
5 can be prevented.
6 And so here is a scenario where yes, in this three month period or two months or one month or five
7 days, children will receive exchange coverage. They will have to enroll in that. And then 90 days later they
8 will have to dis-enroll. So this is the classic case of the kind of entry you are churning that could be
9 addressed with these recommendations.
10 EXECUTIVE DIRECTOR SCHWARTZ: There are really two scenarios there. One is they can
11 afford to get the exchange coverage and there is churning associated with that. And the other is Sara's other
12 one which is they can't afford to get the exchange coverage so they just remain uninsured while the parent
13 might have coverage, self-only coverage.
14 COMMISSIONER CHAMBERS: Yes. Okay. That is what I was trying to get clarity.
15 COMMISSIONER SMITH: I was going to say why would we even want any amount of time where
16 a child might not be insured. If you do the two -- you have the waiting period and you go into the exchange
17 then you might have different provider networks you are dealing with and through the companies who are
18 in the exchange providing this coverage are going to hate that; are they not? You know putting this child on
19 for 30 days and it seems like it would cost more to do that than --
20 COMMISSIONER COHEN: I know that you don't have cost estimates prepared but I do feel like
21 and by the way I am highly moved by this conversation. I am thinking much more seriously about A. again
22 personally. But I do think this question of cost which is just the other side of the coin of how effective is
23 this actually in avoiding crowd-out. It is virtually the same question but I do think one -- has CBO ever
24 scored something like this? What would other sort of credible sort of sources say about the potential
25 change in behavior or whatever and associated costs around A. versus B.?

1 MR. PETERSON: Well let's just think about how CBO would determine this. So now we are
2 down to 19 states that still have a waiting period of let's say on average two months. In that period a
3 majority of those children would be getting exchange coverage, subsidized exchange coverage maybe.
4 CHAIR ROWLAND: You think they would assume that?
5 MR. PETERSON: Some portion anyway. So what that means is that for that period of time there
6 will be federally subsidized exchange coverage. The Federal Government is already paying for something.
7 If you then substitute CHIP coverage for that federally subsidized exchange coverage for those 17
8 states for those three months for those 5% of kids I am not sure that it is going to be --
9 (Laughter.)
10 CHAIR ROWLAND: Could I ask the Commission members to look in your notebooks to the
11 report that is here called Churning Due to CHIP Waiting Periods to page 2 and 3. And you will see --
12 MR. PETERSON: Tab 5?
13 CHAIR ROWLAND: Tab 5. And you will see which states have decided to eliminate it, which
14 states have just dropped back down to three although Virginia seems to be four --
15 MR. PETERSON: And that's --
16 CHAIR ROWLAND: -- and also what the exemptions beyond the exemptions in the HHS CMS
17 regulation, the exemptions that the states that still have waiting periods have put on to an income
18 determination. And you really have to question again this complexity issue that we face in Medicaid versus
19 the reality of getting people covered and sending out a message for coverage.
20 CHAIR ROWLAND: But I think it is instructive to just see where the states are in that -- Idaho,
21 Iowa below 200, there is none and then they have eliminated it; right?
22 MR. PETERSON: And so while you are looking at that so our purpose here is to present to CBO
23 for scoring what they are hoping is a narrower list of things for them to have to assess. So looking at these
24 options and others that have been mentioned would like your thoughts, what are the take home points for
25 what we should do --

1 CHAIR ROWLAND: But one question is whether any of these states who chose to eliminate it
2 made any kind of a cost -- what motivated Connecticut or Alabama or West Virginia to eliminate it?
3 West Virginia?
4 COMMISSIONER CARTE: There Richard said it.
5 (Laughter.)
6 COMMISSIONER CARTE: Well, just all the issues -- I have discussed -- we have a Board, a public
7 board and I discussed with the Board that churning would be a concern once we reach the ACA, that it
8 would be problematic just for reasons of administration simplification we needed to do this.
9 And just to give you the full picture actually the Board moved to do that right after this
10 Commission's summer retreat. But they didn't approve it on the first vote because I had not given them any
11 indicator of whether or not the insurance industry or the insurance commission in West Virginia -- they
12 wanted some process related way to look at it aside from just taking my word for it, which I thought they
13 should.
14 (Laughter)
15 COMMISSIONER CARTE: So I asked the CEO for West Virginia's Blue Cross Blue Shield -- it is
16 not West Virginia, it is High Mark now and their CEO did give me a letter saying that he thought it would
17 be better for those families who would be picking up coverage in the exchange. And then we held a
18 subsequent meeting and they passed it.
19 CHAIR ROWLAND: Donna and then Andy.
20 COMMISSIONER CHECKETT: Another technical question as I am trying to make sure I
21 understand this. How, if at all, does the fact that unless you meet one of the exemptions a family can't just
22 apply to the exchange kind of any time they want. I mean you really can apply for Medicaid or CHIP any
23 time you want. You actually can't do that with the exchange and so that makes me wonder if there is a
24 whole other set here of issues that we should worry about. I almost hate to raise it and I might not be
25 understanding it well.

1 MR. PETERSON: No it is a good point. So really a con of B. is that this is only going to be -- that
2 exchange coverage is only going to be available to those parents during that open enrollment period. And
3 so outside of that then the CHIP kids are affected by that open enrollment period in exchanges and cannot
4 access eliminating the waiting period under B.

5 COMMISSIONER CHECKETT: I think that is more information for us to think about. Again I
6 guess I think isn't the open enrollment period about four months once we get into the second year; is that
7 correct.

8 CHAIR ROWLAND: It is much shorter. Three months.

9 COMMISSIONER CHECKETT: Or shorter than that. It is like three months even. It is not like
10 you can just get in anytime you want and people really don't understand that. And I think we cannot forget
11 that fact, unless there is a qualifying event.

12 CHAIR ROWLAND: Okay. I have Andy and then Trish.

13 COMMISSIONER COHEN: Another technical question and then maybe a point. I do think that
14 personally some of the most persuasive conversation about this is around the alignment with the treatment
15 of other policies and programs and sort of changes under the ACA about the expectation of insurance. And
16 certainly I agree the hope is that the waiting period, that what it does is it means no child goes uninsured
17 and the parent keeps what the kids has but obviously that might not always happen. And it does seem like
18 an awfully kind of punitive disincentive for avoiding crowd-out.

19 I guess my question is in the exchange there is though another sort of like there is an eligibility sort
20 of factor around your access to other insurance which does not exist really in CHIP. In other words if you
21 are willing to put your kid through three months of uninsurance you can take -- I believe you can take them
22 out of employment -- ESI and put them in CHIP. And the price you pay is your kid is uninsured for three
23 months.

24 And I guess I wonder if we should -- first of all do I understand that correctly that in the exchange it
25 is not a waiting period but it is some other sort of set of policies that attempts to go at the crowd-out issue

1 and I just wonder whether we should -- I am sure there are many reasons not to. But I just wonder if we
2 should explore it for a few minutes or in your work whether or not there is a comparable thing to sort of
3 consider or make an option for states to consider in CHIP so that we really are sort of aligning the policies.
4 The ideas is not necessarily, unless we want it to be, sort of access for anyone who just prefers CHIP to
5 what they have. Not that that would necessarily be a bad thing. But you know it is not sort of the policy
6 that we generally have now versus having these waiting periods which really again don't probably do what
7 they are intended to do very well. And furthermore even if they do it is an awfully kind of punitive way of
8 going about it.

9 COMMISSIONER RILEY: This from two angles. From the families' perspective these are low
10 income families. And so eliminating the waiting -- we know there is going to be an affordability issue in this
11 program so eliminating the waiting period helps the family without argument given that there is an income
12 limit here.

13 From the State's perspective though you can never satisfy the waiting period. So these kids -- if you
14 eliminate the waiting period these kids will always be a state responsibility under CHIP. So to that degree I
15 would ask have -- but we see from the action of the states that there is reason to believe that we can support
16 eliminating the waiting period because states are accepting that obligation. That seems to be the trend. But
17 do we have any other information from the states about the costs of eliminating the waiting period.

18 CHAIR ROWLAND: Trish I suggested to Anne that as a follow-up for us for our next meeting or
19 in the interim that we confer with some of the states that are retaining it and some of the states that are
20 eliminating it to get a sense of their decision process just like we put Sharon on the spot to talk about West
21 Virginia. And I think that clearly the second option seems to me to be one that has more complexity and
22 more downsides that we should either look at A. or at C. And that will depend in large part on really what
23 we get back as some of the information from the states about the course of their decision.

24 And about our own analysis of how we make -- we are looking at seamless coverage and how to
25 make coverage more seamless. And so we have got the Medicaid policy where you don't have a waiting

1 period and you can just come in based on income. And now we really need to look at how CHIP fits into

2 that.

3 And I would argue that the ACA considers Medicaid and CHIP almost seamless for children. And

4 that we ought to try and make our recommendation fit that.

5 So for the need to move on here let's have those issues as ones that you will tease out and bring

6 back to us with kind of a more of the implication of each of the options that we are proposing.

7 Richard?

8 COMMISSIONER CHAMBERS: I just wanted to clarify. Didn't we say A. is Congress or the

9 administration HHS; right?

10 CHAIR ROWLAND: Right. Yes.

11 COMMISSIONER CHAMBERS: And so we are going figure that out, too.

12 CHAIR ROWLAND: We need to find out what level would have -- whether it is a statutory or a

13 regulatory change.

14 So now let's take on the next issue which is CHIP premiums.

15 MR. PETERSON: CHIP premiums are also policies that are in the statute, permitted to prevent

16 crowd-out particularly at higher income levels.

17 In January 2013, 33 states used CHIP premiums, and premiums affect approximately 44 percent of

18 CHIP-enrolled children or 3.4 million.

19 It is also interesting to note that the average dollar amount of CHIP premiums has been increasing

20 over time. That is also not -- partly a function of the fact that as state increased eligibility levels to higher

21 income individuals they were charging greater premiums. And you see that here on this slide that only 27

22 percent of kids in the 100 to 150 range face premiums and it is relatively small versus those where it is

23 higher income level where above 250% of poverty almost all the children face premiums of some sort.

24 The current federal requirements are that Medicaid premiums are prohibited below 150% of

25 poverty. But they continue to be permitted in CHIP. Overall we know that CHIP premiums and cost

1 sharing combined cannot exceed 5% of income. And the new CMS regulation, the short story is that CHIP
2 premiums can continue below 150% of poverty.
3 So what is magical about 150% of poverty? Do premiums have a distinct effect below 150% of
4 poverty versus above? So if we look at this figure on the left with all kids what you see is in the presence of
5 a $10 a month premium it would reduce public coverage by two percentage points. And increase private
6 coverage by two percentage points. And have an even smaller effect really small effect on the uninsured.
7 So above 150% of poverty the effect of a premium is smaller. That is to say families above 150% of
8 poverty just seem to be less sensitive to the presence of a premium. But most of that crowd-out is from
9 private coverage. It has little effect on the uninsured.
10 I also think it is important to note that in that particular part we are talking about less than two
11 percentage points. So even if there is some effect it is on the whole pretty small.
12 When we look below 150% of poverty what this shows is that families are more sensitive to that
13 effect, that premium. And that it has the effect of increasing uninsurance among children.
14 Another question is well what happens for those children where the parents are offered coverage
15 versus where they are not. So you see where parents are offered coverage where a premium exists it
16 increases private coverage and again two percentage points. Where parents are not offered coverage the
17 premium has as much an impact on the uninsured as it does for private coverage.
18 But then when we look on the far right where children are below 150% of poverty and their parents
19 are not offered coverage there you see the largest effect where the premium causes public coverage to be
20 much lower and uninsurance accounts for the majority of where those children end up.
21 So that is issue number one with respect to premiums is 150% of poverty.
22 Issue number two then is CHIP and exchange premium stacking. That is to say that in 2014 families
23 can be subject to both CHIP and exchange premiums. And also as we have talked about the fact that a
24 parent is enrolling in exchange coverage means they are not offered affordable ESI. So there is that crowd-
25 out provision that exists in exchange coverage that does to currently align with what is in CHIP.

1 So just in terms of some background on exchange policies. If you enroll in the second lowest cost
2 Silver Plan in the exchange, this is what you are supposed to pay out of pocket for your premiums by your
3 FPL level. So at 150% of poverty you are not supposed to pay more than 4% out of pocket for premiums.
4 So what do these mean in terms of dollar amounts. So just for exchange coverage then for a family
5 of three with one parent and two children and assuming the kids are in the CHIP income range if there is no
6 CHIP premium then this is what the family pays for the exchange premiums and that is it. Or even if the
7 state didn't have a CHIP program at these particular levels exchange coverage once the parent has satisfied
8 and met that cap for what they pay out of pocket then this is the premium that they would pay for the
9 whole family for the second lowest cost Silver Plan. But in the case that there are CHIP premiums then we
10 just put in some examples that are typical based on the Kaiser Report from earlier this year. Then this is the
11 combination or stacking of the CHIP and the exchange premiums.
12 FEMALE SPEAKER: (Off Microphone)
13 MR. PETERSON: Right. In your commissioner materials it’s on page 6 and you can see the
14 different income levels. So this is on the CHIP Premiums paper, Table 1. So at 151 percent of poverty, it’s
15 $29,490. So this figure is just showing just a little bit of that information that’s in this table.
16 My point was -- though, if the parent has already met that cap for exchange coverage, and CHIP was
17 not available, and the kids were enrolled in the exchange coverage with the parent, then those kids would
18 not cost an additional amount because the family has already met that cap. So the options --
19 FEMALE SPEAKER: (Off Microphone)
20 MR. PETERSON: That’s right. That’s just premiums. That’s not cost sharing for deductibles, etc.,
21 which is, another kind of stacking for another day.
22 Options for CHIP premiums:
23 A. Is to look at the 150 percent issue separately. “Consistent with Medicaid, Congress should
24 eliminate CHIP premiums at or below 150 percent of poverty;”
25 Then separate from that is addressing this premium stacking issue.

1 B. Says "Congress should eliminate CHIP premiums where parents have subsidized exchange
2 coverage;"
3 C. Is "States should eliminate CHIP premiums where parents have subsidized exchange coverage,"
4 and;
5 D. Is "Congress should permit states to enroll to allow children facing CHIP premiums to enroll in
6 their parents' exchange coverage."
7 And actually, David, to your earlier point while it's not -- it hasn't been made explicit that premium
8 assistance in CHIP to purchase exchange coverage is permitted. I think "D" is really, premium assistance
9 could be a way to accomplish "D."
10 COMMISSIONER RILEY: Question for clarification. Can states do that without a congressional
11 change on issue "C"?
12 MR. PETERSON: I would -- I believe so given the flexibility that states have in terms of setting
13 their premiums. The only concern would be whether that would come into conflict with the fact that you
14 can't have higher income kids better off than lower income kids, but if it doesn't fail that test then it should
15 be permitted.
16 CHAIR ROWLAND: Do we know to what extent any of the states depend on the premiums to
17 help offset the cost of their CHIP program? Their state match?
18 MR. PETERSON: Well you can -- in the appendix table you can see that the amounts of the
19 premiums can be quite large. I think that's in the very back of that tab where -- it's the Kaiser tables that
20 show the amount of the premiums.
21 So I think they would say, yes, that's one of the reasons that they do it so it's not only crowd-out,
22 but it's to raise money for themselves; particularly, as was mentioned earlier, in the presence of the
23 maintenance-of-effort, so states cannot rollback their eligibility levels. They have these premiums, and if the
24 premiums then go away, and states must continue to cover children in Alabama up to 300 percent of the
25 poverty level that could be perceived as problematic.

1 COMMISSIONER COHEN: I know there's an answer to this. There's a probably a reason that we
2 can't do this, but could another option be to allow -- which I think is discussed in the paper -- to allow
3 CHIP premium contributions to count towards the parents' sort of contribution, for purposes of the
4 calculation of the subsidy in the exchange?
5 And I suggest this -- again, there may be a very good reason that we can't do it -- because I think
6 based on our conversation this morning, we wouldn't necessarily say today that exchange coverage is
7 comparable for kids, and because I'm concerned that the cost to states and the other pressures on states
8 from eliminating their premium income could have effects that we would certainly need to think about.
9 In other words that it's a significant amount of money in some states; so you know the idea of
10 instead contemplating this as -- and it frankly, also, makes more sense.
11 The point under the ACA is there should be a maximum amount that families contribute towards
12 health care. And the fact that one state has a CHIP program and the kid has to go in there, you know first,
13 but it's at different levels like it's sort of -- it is -- it doesn't really make sense that the variability of state
14 premiums and state CHIP programs and their eligibility levels affect so much what a family actually has to
15 pay to get the entire family covered.
16 MR. PETERSON: I think that "B" tries to accomplish that in a simple way without having to
17 actually add up the numbers. So if parents are qualifying for subsidized exchange coverage, it means they've
18 already hit that cap, which means, to go with the principle is that once they've met that cap they should be
19 done. I think the way you're wording it is more that there should be kind of separate calculations and
20 somebody needs to add those up together for the CHIP program plus the exchange coverage and work that
21 out.
22 COMMISSIONER COHEN: I see. I see it. I do think "B" works.
23 COMMISSIONER ROSENBAUM: I do think though -- and it's interesting because I mean we're
24 sort of coming at the same problem and maybe in two different ways. So my reaction was I think essentially
25 you would -- if I understand what you're asking, you essentially shift the financial burden to the premium

1 subsidy because essentially, there's a new deduction given -- okay -- which would, I think, require a statutory
2 change because it's not part of the MAGI test, obviously.
3 And my reaction was sort of the inverse, which is that there should be a limit on what could be
4 charged for CHIP and the limit should be the maximum amount that a family would have to pay for family
5 coverage for a family of that size were it to have bought a family plan on the exchange.
6 So looking at the stacking problem, it seems to me that the stacking problem here, is precisely that
7 you take say, self-only and spousal coverage, and then you add on you know, like in Virginia $40 a month
8 for each child and you get to the number.
9 The question in my mind, is what would that family have had to pay had the family had the ability to
10 simply buy a family plan in the exchange? So we're preserving state's ability, at any income level, to charge a
11 premium under CHIP, but we're saying that your ability to charge can be no greater than, what now
12 superseding national policy has set as the maximum amount of financial exposure for a family of that
13 income level.
14 I mean it's the same problem over and over again, which is we have, you know, not as antiquated in
15 some ways as Medicaid that's newer, but we have a 16-year-old antiquated program, and we have superseded
16 that antiquated program and the whole series of policies now, one having to do with affordability, one
17 having to do with coverage, and so if we think about this as kind of modernizing CHIP's essentials in order
18 to allow ultimately a glide path from CHIP into a unified system, then what we want to do each time to start
19 reflecting those policies in CHIP policy. And I assume that on either way it would be a limitation on state
20 discretion and you would need statutory language.
21 CHAIR ROWLAND: And Sara, wouldn't you also need to specify which plan in the exchange --
22 COMMISSIONER ROSENBAUM: Yeah.
23 CHAIR ROWLAND: -- which level?
24 COMMISSIONER ROSENBAUM: You have to tie it to the second lowest cost level or whatever.
25 Yeah. Yeah.

1 CHAIR ROWLAND: Okay.

2 VICE CHAIR SUNDWALL: I need clarification. And I think Sara and others mentioned this
3 morning, there is no such thing as an essential benefit package for children's policies.

4 COMMISSIONER ROSENBAUM: There is the CHIP Benefit Design, which is much more
5 limited in its minimum requirements and federal statute so many, many states, as we heard this morning, go
6 well beyond the minimum statutory requirements. The question is, now that we have a re-establishment of
7 a benchmark, a benchmark that covers children. Okay?

8 VICE CHAIR SUNDWALL: Um-hmm.

9 COMMISSIONER ROSENBAUM: We've essentially superseded the old CHIP benchmark with a
10 new benchmark that is supposed to apply to adults and children. I mean there will be children in the
11 exchange plan.

12 VICE CHAIR SUNDWALL: The benchmark in the -- do you mean in the --

13 COMMISSIONER ROSENBAUM: The essential --

14 VICE CHAIR SUNDWALL: -- exchange --

15 COMMISSIONER ROSENBAUM: -- health benefit --

16 VICE CHAIR SUNDWALL: Right.

17 COMMISSIONER ROSENBAUM: -- you know design.

18 VICE CHAIR SUNDWALL: So that would apply to kids? Because I could be -- you know I really
19 do like option four; using public dollars to buy private insurance. If we had the confidence that their level
20 of benefits were not significantly lower than, they might have gotten in CHIP. So you think that that
21 wouldn't be a problem?

22 COMMISSIONER ROSENBAUM: Well, I think, if anything, the problem may go -- and I must
23 say it may be that more light will be shed on this because of a couple of studies that are outstanding at this
24 point. And my understanding is they're outstanding we don't have the benefit design studies yet.

25 It may well be that we find that states have used their flexibility under CHIP to go beyond EHB, the

1 Affordable Care Act standard, but I doubt it because if you look at the 10 EHB classifications, the
2 classifications cover, in theory, basically everything. Now what a state could do, if we were to figure this out
3 in the glide path, is to use that pediatric benefit class that is in the EHB classifications.
4 One of the classifications is "pediatric benefits" that's where vision and dental live right now. But
5 there's no reason why a state couldn't say, if we, you know, modified and sort of tried to merge CHIP and
6 pediatric design in the long term, that we expect the pediatric benefit design to actually capture a little bit
7 more for children: lower cost sharing, a more expansive level of treatment.
8 You can do -- I mean right now a state could do that they're just not doing it. But I don't think the
9 danger is that states -- that entire benefit classes would disappear. If anything, it may be the opposite
10 direction; the benefit classes will appear that aren't in some state CHIP plans today.
11 CHAIR ROWLAND: I think we also have to be cautious here while we're talking about premiums.
12 We're not --
13 COMMISSIONER ROSENBAUM: Right.
14 CHAIR ROWLAND: -- There's also the whole issue of the cost sharing levels --
15 COMMISSIONER ROSENBAUM: Right.
16 CHAIR ROWLAND: -- and the difference between coverage in CHIP and the cost sharing there,
17 versus what you would get in the exchange plan.
18 MR. PETERSON: And Diane, I want to bring something up to piggyback on the point, the
19 question that you asked earlier -- kind of -- about state's reactions to this and premiums and how they feel
20 about it. I think the conversation today is helpful for us to think about how CHIP waiting periods and
21 CHIP premiums differ, because what we're seeing on CHIP waiting periods is, half the states in the past
22 year have gotten rid of them. We're seeing a sea change in that --
23 CHAIR ROWLAND: Right.
24 MR. PETERSON: -- on their own and Alabama is an example of that.
25 On the other hand, Alabama is increasing their premiums to the maximum extent possible and as

1 Cathy said, states like, some legislatures, they like those premiums. And so I think these two options,
2 although they're structured similarly, it's about crowd-out and the interactions, that they are very different,
3 and I just want you to keep these things distinct in that way.
4 CHAIR ROWLAND: And you did say that premiums constitute a second category that you can
5 document if you have a crowd-out policy. Trish?
6 COMMISSIONER RILEY: I just -- I think Chris make's a really important point because when we
7 think -- I'm having -- struggling with short term versus long term, because a short term solution has to be
8 able to be implemented short term.
9 And so when you think about messing with premiums in this environment where so many states are
10 talking about "skin in the game," and even though we know these are poor people, but this is a -- you know,
11 look at Arkansas, look at the interest among states in making sure they have premiums.
12 It strikes me that the politics of this one will be really challenging so you know whether we can get
13 Congress to act quickly anyway, but in an environment where states are using premiums for their revenue
14 streams, where they're increasingly interested in personal responsibility, is there a different way that we can
15 approach the stacking issue? Because it's clearly a short-term problem, but I don't see a short-term solution.
16 COMMISSIONER CARTE: I'd just like to point out that the stacking issue might not be as severe.
17 It's not always a per-child premium. Sometimes the premium is capped. So if it's capped it's not like -- in
18 our state we don't charge when you have four kids, four times the single premium.
19 CHAIR ROWLAND: Maybe it would be helpful to get more information on what the nature of the
20 premiums being charged are, and also how the eligibility levels of the states -- I mean very few states are up
21 at 300 percent of the federal poverty level. And I saw that some may be exempting at different levels in the
22 waiting period, so do they -- how do they handle where the premiums even start?
23 Norma? And then Donna.
24 COMMISSIONER MARTINEZ ROGERS: I think that even if its $120, for a family that's poor,
25 $120 is a lot. When you look at the people that are on food stamps and the decrease in food stamps at $120

1 could mean something that they no longer have to put food on their table. I mean I think that we need the
2 information that you suggested in order to really be able to make a decision.
3 COMMISSIONER CHECKETT: I -- yeah -- too, I mean it's been a really, really interesting
4 discussion, but I guess just if you start to round up -- I'm really concerned about this prospect that we
5 would have a child going onto an exchange product for a short period of time and then going back to
6 CHIP. And it's just a problem for a whole host of reasons.
7 It's a problem for how you know insurance companies set rates. It's a problem for providers
8 because of the confusion in billing and settling up, and you know for somebody being in the middle of a
9 treatment plan in, you know last, and in most it's just incredibly confusing for the family. So I really think
10 we need to think about that in terms of a recommendation.
11 FEMALE SPEAKER: (Off Microphone)
12 COMMISSIONER CHECKETT: Yeah it's just nuts.
13 COMMISSIONER SMITH: What are the consequences to a family who either can't pay the
14 premium, don't pay the premium, or don't enroll their child? Because there is a premium. What are the
15 consequences for not having a child enrolled, or for having the child enrolled, but not paying the premium?
16 I'm just curious.
17 COMMISSIONER ROSENBAUM: You are penalty-liable for not enrolling your child in
18 affordable coverage just like you would be penalty-liable for doing -- for not doing it yourself. And I don't
19 remember the formula.
20 CHAIR ROWLAND: But as long as -- but you'd have to be a tax filer.
21 COMMISSIONER SMITH: Absolutely.
22 COMMISSIONER ROSENBAUM: Right.
23 COMMISSIONER ROSENBAUM: No.
24 CHAIR ROWLAND: So for the very lowest income --
25 COMMISSIONER ROSENBAUM: If you're subject to --

1 CHAIR ROWLAND: -- families, there --

2 COMMISSIONER ROSENBAUM: -- a penalty, then you would be subject to a penalty for your

3 child versus yourself, but the -- and the penalty is some pro rata portion. I don't remember what it is.

4 COMMISSIONER SMITH: And if the child needs medical care during that period of time what

5 happens? What do they do? Who gets charged?

6 COMMISSIONER ROSENBAUM: Well if you're in a state, if you're in a -- I mean if you have a

7 child -- if you have access to affordable coverage for a child, and assuming you're liable for a penalty, then

8 you know, if you don't get the coverage, you don't get the coverage.

9 If you happen to be in a state with a medically needy program, for example, as part of Medicaid, you

10 might be able to get some coverage for the child through a Medicaid spend down that doesn't go away.

11 And you know depending on other indigent care programs, you might get benefits there, but I mean…

12 CHAIR ROWLAND: Well wait a minute, but if you're really low income, the child --

13 COMMISSIONER ROSENBAUM: Oh, no, no. If you're --

14 CHAIR ROWLAND: -- you're eligible for Medicaid.

15 COMMISSIONER ROSENBAUM: -- very low income, then --

16 COMMISSIONER SMITH: Right.

17 COMMISSIONER ROSENBAUM: -- well then you're not penalty-liable --

18 CHAIR ROWLAND: Right.

19 COMMISSIONER ROSENBAUM: -- either. You're below the tax filing status.

20 CHAIR ROWLAND: But I think Robin is asking…

21 COMMISSIONER SMITH: Yeah. I'm talking about the people who do qualify for CHIP --

22 COMMISSIONER ROSENBAUM: And don't enroll.

23 COMMISSIONER SMITH: -- you know within their income, but either, don't enroll because they

24 feel like it's cost-prohibitive --

25 COMMISSIONER ROSENBAUM: Right.

1 COMMISSIONER SMITH: -- to them because of the premiums --

2 COMMISSIONER ROSENBAUM: Right.

3 COMMISSIONER SMITH: -- and the copays. And I know people who would think that --

4 COMMISSIONER ROSENBAUM: Absolutely.

5 COMMISSIONER SMITH: -- or they just simply --

6 COMMISSIONER ROSENBAUM: Or if they're --

7 COMMISSIONER SMITH: -- don't enroll?

8 COMMISSIONER ROSENBAUM: If they're below the -- if they're --

9 COMMISSIONER SMITH: Or they enroll the child --

10 COMMISSIONER ROSENBAUM: Right.

11 COMMISSIONER SMITH: -- but then don't pay the premium.

12 COMMISSIONER ROSENBAUM: I mean there will be CHIP-eligible families that are above the
13 tax filing status. CHIP in some states goes up --

14 CHAIR ROWLAND: Um-hmm.

15 COMMISSIONER ROSENBAUM: -- rather substantially. And now, I mean the obligation to
16 enroll in affordable coverage extends to anybody. You're penalty-liable if your income exceeds a certain
17 threshold. And there are many, many families whose incomes exceed the certain threshold.

18 Look at New York; in New York State, the CHIP program goes up to 400 percent of the federal
19 poverty level. But so this is why -- and I mean it's important to understand that although you may be
20 moderate income, you may well be liable for the penalty.

21 COMMISSIONER MOORE: And if people enroll and don't pay their premiums they just get
22 kicked out?

23 CHAIR ROWLAND: Right.

24 COMMISSIONER MOORE: And then I don't know, you know how the newer systems are going
25 to take those kinds of things into account in terms of the mandate and the other penalties.

1 CHAIR ROWLAND: Okay. Sharon?

2 FEMALE SPEAKER: (Off Microphone)

3 CHAIR ROWLAND: Oh, okay. Chris?

4 MR. PETERSON: So then what we're looking for is whether Option A is worth pursing, which is
5 whether premiums for CHIP should be eliminated below 150 percent of poverty, as is the case for
6 Medicaid, and then it's whether you want to consider other options around family premium stacking or not.

7 CHAIR ROWLAND: I think this is clearly an area where we need more information on what states
8 are where and how many individuals this would affect. And so I think this is clearly one where we're going
9 to ask you to come back before we can choose an option or whether to go forward with any option just to
10 provide us with more analytic information.

11 COMMISSIONER COHEN: This is like for the -- it basically just covers a band of 12 percent of --
12 12 percent from 138 to 150.

13 CHAIR ROWLAND: Okay.

14 COMMISSIONER COHEN: I mean --

15 CHAIR ROWLAND: And how many kids fall into that area.

16 COMMISSIONER HOYT: These are mutually exclusive options right?

17 COMMISSIONER COHEN: No.

18 COMMISSIONER HOYT: You could do number one --

19 COMMISSIONER COHEN: You could do one --

20 COMMISSIONER HOYT: -- and then do something else beyond that too.

21 COMMISSIONER COHEN: -- yeah. Yes.

22 CHAIR ROWLAND: Right. Correct. Is there any other information that others would like Chris
23 to come back with to help facilitate our ability to sort through this increasingly complex issue? Trish, Sara --

24 COMMISSIONER RILEY: I think maybe --

25 CHAIR ROWLAND: -- and Andy.

1 COMMISSIONER RILEY: -- because on a stacking chart it -- you know stacking implies
2 redundancy and that's not necessarily -- if the family is exchange-eligible and doesn't buy family coverage --
3 so it's just the dad or the mom buying coverage, then the CHIP premium is an add-on.
4 So you know it's messy and it's sloppy and it's not simple, but it's -- I'm buying my individual
5 product in the exchange, I'm paying a premium to CHIP, so I'm paying -- how would that compare
6 financially, if I picked up dependent coverage or child-only coverage in the exchange?
7 MR. PETERSON: Yeah. And that's why I was saying where, if the family has already met -- just
8 for the parents' coverage, if they've already met that cap on out-of-pocket premiums for exchange coverage,
9 then adding the kid in the second-lowest-cost silver plan would have no additional cost.
10 EXECUTIVE DIRECTOR SCHWARTZ: But adding the kid in CHIP would.
11 MR. PETERSON: But adding the kid would, if they're charging premiums.
12 FEMALE SPEAKER: (Off Microphone)
13 MR. PETERSON: Right. And I'll also say that we don't have the ability under the CHIP
14 administrative data to look at a cut of those below 150 percent of poverty, because the range that they
15 provide is between 100 and 200. So we had tried to make some estimates based on what we had. It's also,
16 how we came up with the estimates that 3.4 million children are affected by CHIP premiums, 44 percent --
17 EXECUTIVE DIRECTOR SCHWARTZ: Um-hmm.
18 MR. PETERSON: -- of CHIP kids. So we did the best we could with the data. And those parents
19 ostensibly are -- you know, they're all in the exchange-eligible income range so I'm not sure we could give
20 you -- how much more information we could give you based on the data that exits.
21 CHAIR ROWLAND: Burt and then Sharon.
22 MR. EDELSTEIN: Yeah. I just wanted to point out that there's an analogous stacking problem
23 that is smaller, but we haven't discussed it. And that has to do with the fact that if in the exchange you
24 purchase your dental separate from your medical then those costs are stacked on top of each other as well,
25 which is another unintended consequence of trying to accommodate the stand-alone dental plans.

1 FEMALE SPEAKER: (Off Microphone)

2 COMMISSIONER CARTE: I think it came back to me.

3 FEMALE SPEAKER: (Laughs.)

4 COMMISSIONER CARTE: Chris, would it be possible to get the data for each state? Like when
5 you talk about the premiums, for example, in West Virginia I think it would be good to know at what level
6 of income if a premium is being paid. Because actually, we toss around the term "premium" lightly, but in
7 fact, some of the CHIP programs that have a so-called "premium" it's a really nominal enrollment fee of --

8 MR. PETERSON: So if you look in the --

9 COMMISSIONER CARTE: -- $10.

10 MR. PETERSON: If you look in the CHIP premium stacking paper at the end of that are the
11 Kaiser tables. It shows you based on the -- all of the various income levels what the premiums are.

12 In the example that I had given in the paper, for example, I had two states that were $30 a month. I
13 originally had three states, but took that out because as somebody mentioned, there's a family cap. So you
14 know it was capped for the state that I took out at $50 for the whole family.

15 COMMISSIONER CARTE: Right.

16 MR. PETERSON: So all of this information, a lot of it I think is in this material.

17 COMMISSIONER CARTE: Okay. That's the one on --

18 EXECUTIVE DIRECTOR SCHWARTZ: We can bring that back --

19 COMMISSIONER CARTE: That's Table 1?

20 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. Table 16 and Table 17, though, I think we can
21 bring it back a little bit more condensed for you to take these Kaiser figures and make it easier to navigate
22 for the next conversation.

23 COMMISSIONER ROSENBAUM: I meant to raise this before when we were talking about the
24 crowd-out, and I wonder if it could be done, which is a table that's a longitudinal table running from say, the
25 mid '70s through now, showing changes in ESI for children before and after. I know it's been done for

1 adults.

2 And I don't know if Urban, for example, can give us a longitudinal table. I mean I know there's a

3 matching issue, before and after, from the data sources. Before and after '96, I think, was the year.

4 But I think it would be -- I had wanted to raise it in the earlier discussion -- and I think it would be

5 very useful for us to have in front of us, as we go through all of these things, some relatively long term

6 picture of how public and private insurance coverage for children have traded off employer-sponsored

7 Medicaid and then the advent of CHIP, into essentially what is an individual market.

8 And then of course this issue, which we can't chart yet, but the potential market, which children will

9 end up in the individual market that is the premium subsidy market. And those will obviously be children

10 who are qualified for a subsidy, but are over their CHIP eligibility standards for their state.

11 So again, I don't know what's involved in creating this, but I think part of what we need to do here

12 is, the optics of changing children financing and producing a picture for everybody of what we think the

13 history of child financing is like, since the apex of employer coverage, roughly in the mid '70s to today,

14 would be very useful.

15 CHAIR ROWLAND: It would be a nice setting for looking at a longer range trajectory of -- as we

16 go to the future of CHIP, we obviously have transition issues and then we have kind of what direction

17 should children's coverage be going.

18 MR. PETERSON: All right. So now moving to the future of CHIP, as was talked about earlier,

19 there are no new federal CHIP allotments after 2015. It's important to note though that the authorization

20 does not officially expire and states will enter 2016 with unspent CHIP funds -- federal CHIP funds. And

21 so they will be able to use those throughout fiscal year 2016, ostensibly running out during that year.

22 In addition, state's CHIP matching rate is increased by 23 percentage points from 2016 through

23 2019, so through the duration of the maintenance-of-effort. As has been talked about, children's Medicaid

24 and CHIP eligibility levels cannot be reduced before FY 2019.

25 When the CHIP funding runs out after 2015, when states run out in separate CHIP programs,

1 children may enroll in subsidized exchange coverage if it's available to them. And those subsidies, of
2 course, are 100 percent federally financed.
3 As Colleen Sonosky talked about -- from the District -- she's in a Medicaid expansion program and
4 she would be required to continue those children's coverage in Medicaid -- and that would be at that point
5 once the CHIP money runs out -- from Medicaid funds at the regular Medicaid matching rate.
6 Again, Medicaid has generally comprehensive benefits with no cost sharing, with an average federal
7 share of 57 percent. Individuals are entitled to Medicaid with uncapped federal financing. CHIP differs in
8 that it's state flexibility around benefit design and cost sharing with more federal share.
9 There is no individual entitlement, although that is affected somewhat by the maintenance-of-effort,
10 where states can't rollback or take certain actions. Then there is also capped federal financing.
11 And then to contrast that with subsidized exchange coverage, which has ostensibly more flexibility
12 around benefit design, certainly greater cost sharing. And again, those subsidies are 100 percent federally
13 financed, and tax payers are entitled to that coverage with uncapped federal financing.
14 One of the ways that we can assess affordability in a single value, is an actuarial value, which tells us
15 the percentage of the covered benefits that are paid for by the plan. This was an analysis that was done a
16 few years ago. In all but one case, the actuarial values were all above 95 percent.
17 The exception was West Virginia back then. And my understanding, based on discussions with
18 Sharon, is that they would also be higher and above that 95-percent threshold based on changes that they
19 have made in their program since then. Contrast that to what is available for subsidized exchange coverage,
20 which is lower. So it raises a question of the affordability of coverage for those children.
21 So these are issues that came up earlier today that when we talk about eligibility, enrollment, yes,
22 CHIP had a historic role in lowering un-insurance through marketing, outreach, the CHIP branding,
23 enrollment simplification efforts. And without CHIP un-insurance could increase not only because children
24 may not be eligible for exchange subsidies; they may be eligible but not enrolled.
25 On the other hand many of CHIP's outreach and enrollment efforts are now ingrained throughout

1 Medicaid and CHIP. The small size of the program leads to churning, and many of CHIP's unique policy
2 levers are unavailable because of the ACA's maintenance-of-effort.

3 With respect to affordability, we've talked about how premiums are charged in CHIP in most states.
4 That there could be exchange premium stacking, or in the absence of CHIP that parents could enroll their
5 children in their exchange coverage with them with no additional premiums.

6 With respect to cost sharing, CHIP does permit cost sharing, unlike Medicaid generally, but we see
7 from those earlier figures that CHIP cost sharing is less than subsidized exchange coverage.

8 With respect to benefits, CHIP generally covers more than an exchange. And there are analyses
9 currently underway that hopefully will shed some light on this.

10 What was also talked about is that separate CHIP programs are often touted as having broader
11 networks in Medicaid. It is unclear how the exchange networks will look different from CHIP, especially
12 with respect to children's providers. And the financing, again, no allotments after 2015.

13 So if CHIP does not continue, there is this inequity potentially between the Medicaid expansion
14 states who have to continue to offer Medicaid to these children at the regular Medicaid matching rate.
15 While the separate CHIP programs, those children can go to exchange coverage and there's no state share
16 involved in that.

17 As we talked about before with respect to what CBO has to assume, it could be that the federal cost
18 of extending CHIP may be smaller than what one might otherwise think. Again because in the absence of
19 CHIP, many of these children are going to receive Medicaid or subsidized exchange coverage, and so on net
20 it may not be substantial.

21 Some policy questions are:

22 If you extend CHIP for how long?

23 Do you do a permanent extension because CHIP should be maintained, or do you do a temporary
24 extension until we can assess really what's going on with exchange coverage?

25 Should the maintenance-of-effort continue in that case that you extended, or should states be able to

1 reduce their CHIP eligibility levels?

2 And then should that 23-percentage-point bump in the enhanced match go into effect?

3 If CHIP is not extended, will the covered benefits and exchange coverage be adequate?

4 Should the affordability of children's exchange coverage be addressed so if it's as simple as changing

5 the actuarial value for exchange coverage, should that be something considered?

6 And should states with Medicaid-expansion CHIP programs be required to enroll those children in

7 Medicaid, also a maintenance-of-effort question.

8 So with that I'll conclude my presentation.

9 CHAIR ROWLAND: So we essentially have a short-term and a longer-term issue here. The short-

10 term issue is during this transition period. What should be done to make sure that we don't create a gap

11 that kids fall through?

12 And then the longer-term issue is actually, as you try and implement the Affordable Care Act and

13 you go from a Medicaid base for the poorest children, into the exchange and into employer-based coverage,

14 what -- is there a role there for CHIP? And how do you phase out the CHIP role and phase in the new

15 role? If that's where you're going.

16 None of those issues are going to be decided in the next half-hour here, but let's at least give Chris

17 some guidance as to what we'd like him to be looking at, in that framework.

18 Trish and then Andy?

19 COMMISSIONER RILEY: I just had a question that I hadn't thought about before. Maybe it's

20 late in the day. So if you're a separate CHIP program, you can flip them into the exchange. If you're

21 Medicaid-only, they remain in Medicaid beyond the period of maintenance-of-effort, or just to 2019?

22 MR. PETERSON: Through the maintenance-of-effort --

23 COMMISSIONER RILEY: Okay.

24 MR. PETERSON: -- which is through 2019.

25 CHAIR ROWLAND: Andy?

1 COMMISSIONER COHEN: I guess one thing that I wanted to say is -- which is not a direct
2 answer to that question of giving you guidance -- well, maybe it is to me --
3 CHAIR ROWLAND: It can either be guidance or confusion.
4 COMMISSIONER COHEN: Right. We do need to look at the questions together, because to me
5 it's a little bit interdependent. In other words, if our recommendation goes one way on short-term, long-
6 term, then I think our short-term recommendations you know are affected by that very much.
7 So I see them as -- I might feel differently about a short-term -- about a fix if we're thinking about it
8 short-term versus long-term. So I don't know if others feel that way, but I do think we should come to
9 some common understanding about how interdependent they are. So that's one point.
10 I guess I'll just sort of you know take -- I guess I'll just take a crack at what I've you know read from
11 what we know so far and what we heard this morning, which is that -- and what I know from looking at the
12 calendar, 2015 is around the corner and we don't know very much. There's a ton we don't know about how
13 CHIP and the exchanges align.
14 So if there are a multitude of questions, I will take a crack at the first one, which is that I'm not sure
15 that we are ready to say CHIP is gone in 2015.
16 It seems like easy -- maybe easy, but I'm still very, very interested in exploring, and potentially
17 making a more general statement from the Commission about, whether in the longer term, we see -- we
18 would like to develop a glide path. I lean in that direction definitely, but so that's some direction from me.
19 CHAIR ROWLAND: Trish?
20 COMMISSIONER RILEY: I lean on the glide path direction, too, primarily for simplicity. That I
21 think the fewer silos we have of coverage the better, but I'd like to see that recommendation really flushed
22 out. And I think this morning's conversation gave us some real legs.
23 The notion that maintenance-of-effort could be abandoned if certain conditions were met -- if the
24 state found other alternatives, if the state could buy into an exchange and sort of lay out those options --
25 which I think we'd have to think a great deal more about, and I think we really do need to examine the

1 notion of the buy-in.

2 How do we transition CHIP to a buy-in to the exchange? It seems to me to have real legs that

3 wouldn't require us a long glide path, but at least one to get us those -- the planning in place.

4 CHAIR ROWLAND: Because we already have the lower income part of CHIP going into Medicaid

5 so really, now it is what merges with the exchange.

6 Sara?

7 COMMISSIONER ROSENBAUM: I just want to add my support for a series of options that

8 assume that what we are aiming toward -- you know, we don't know the end date -- but what the

9 Commission is aiming toward is a more unified approach to child-health financing -- you know, in Medicaid,

10 which again is a special case with special attributes.

11 The decision, going all the way back to 1967, was to strengthen Medicaid for children. It was not to

12 build a separate program for children. It was to strengthen Medicaid for children.

13 And my great fear about not putting us on a glide path is that as I look at where we are right now,

14 with national health policy in the individual market as reflected in the exchange policy, it's as if every handle

15 for thinking pediatrics was just blunted. I mean the pediatric coverage was not defined. There was an

16 opening left by Congress.

17 But then, it was not defined and it's not devolved into a definition, and we've introduced other

18 problems like the affordability problem. And so, we're now I think heading on a very dangerous path where

19 we have a policy of individual coverage for adults over here, and we happen to have some children mixed in,

20 to a policy of coverage for children, which is a much smaller much weaker program, overall, in terms of its

21 lack of permanence, its weaker financing arrangement, its weaker design features as a national policy issue.

22 And so as you fashion the options for us, I think that we have two things to answer: One is what do

23 we want for some interregnum the CHIP to be, and what things in the long-term either directly or indirectly

24 -- directly is a national matter, indirectly because of new state flexibility -- do we want to see in terms of

25 strengthening the exchange policy?

1 The trends are going to meet up somewhere and we probably should be more articulate than we've
2 been, in terms of thinking about how -- where these policies converge, and what would have to happen on
3 both sides.
4 COMMISSIONER MOORE: I'll just throw out there some thoughts about a couple of things:
5 One is that we could suggest that CHIP be authorized through 2017 or 2019 -- I mean funded, I'm sorry --
6 funded with some thought to the experimental stuff, for 2017, and preparing for that so that it could
7 actually start in 2017, which would mean you'd have to back it up, to thinking about it in 2015, 2016, and
8 some review of this huge jump, the 23 percent increase, which I think almost seems to me as like a
9 placeholder.
10 And I don't think it makes a lot of sense to do that, and I think we need to suggest that financially
11 we probably can't afford that. But we don't want to make it look like we're not emphasizing a child health
12 coverage policy. So I'm concerned about the 23 percent increase and whether that's viable financing policy
13 for children's health coverage.
14 CHAIR ROWLAND: But what if --
15 COMMISSIONER MOORE: So I've sort of rambled around here, but those are some elements of
16 things that I would like to see in options for a recommendation of the language for a longer term pathway.
17 CHAIR ROWLAND: And I think that really needs to be accompanied by what -- if we recommend
18 extending the financing -- what that implies in terms of dollars. And that clearly gets into what the matching
19 rate is, because there could be different recommendations based on keeping the existing matching rates,
20 versus going to this new one.
21 Trish?
22 COMMISSIONER RILEY: It just occurred to me. We might not want to give up the 23-point
23 increase, but recommend that it be used for the family glitch or some other purpose that sort of would get
24 us to the glide path.
25 COMMISSIONER MOORE: Or extended over --

1 COMMISSIONER RILEY: Yeah.

2 COMMISSIONER MOORE: -- or used in the same --

3 COMMISSIONER RILEY: Or used --

4 COMMISSIONER MOORE: -- bolus of money in some --

5 COMMISSIONER RILEY: I don't know.

6 COMMISSIONER MOORE: -- other (inaudible).

7 COMMISSIONER RILEY: I just want to -- I would flag it in some way, as a "potential review," to
8 do something slightly more strategic. That moves into a few more years. Because otherwise, you're just not
9 going to have enough money.

10 COMMISSIONER SMITH: Again I'm tired, I may be way, way off base with this. But going back
11 to the CHIP premiums that we were talking about.

12 If we did number four: "Permit states to allow children facing CHIP premiums to enroll in their
13 parents' exchange coverage," wouldn't that give us a group of children being enrolled into the exchange that
14 we could look at, and see if -- compare which is -- I don't know.

15 CHAIR ROWLAND: I think it would, but we also have the issues of what exchange coverage is,
16 versus CHIP coverage, and those studies are currently underway to look at the differences in benefits and
17 the differences in the cost sharing levels, but you know obviously, part of a projector would be if you do
18 believe families ought to be together that's part of where we would go.

19 And I think kind of having a glide path -- sort of envisioning a glide path and what the steps would
20 have to be, to transition from today to a smoother glide path, would be very helpful.

21 Donna and then Andy.

22 COMMISSIONER CHECKETT: I want to just point something out just so that everybody kind of
23 keeps this in the back of their brains, is that when we talk about a child who's in a CHIP program, even if
24 they are in, say Alabama, where you know they are the CHIP carrier insurance company -- for lack of a
25 better word -- and you can get Blue Cross on the Alabama exchange -- at most you're actually going to keep

1 the child with the same company that insures them, but they are not going to have the same coverage -- and
2 I just think people shouldn't lose sight of that.
3 And in fact -- you know, so that like when you have a family deductible and all those calculations are
4 being done and all those notices, those are not going to apply equally. I mean you're going to get a set of
5 notices for the CHIP coverage. And a different set of notices and calculations -- and in fact, it would you
6 know probably not -- I don't know.
7 It would be interesting to look at where the states -- where the CHIP carrier or managed care plan --
8 how much of those -- how many of them are also, on the exchange. And I think it's going to be very, very
9 mixed, which is just another continuity issue so, but I just wanted to remind people because you hear a lot
10 about bridge plans, but when you really poke at it and look at it, you know there isn't actually one.
11 Yet because that to me is like a single coverage product that you're enrolled in, that is covering all of
12 you even though you have different entities paying for your coverage. I'm not aware that anybody's got that
13 anyplace, so anyway, just something to keep in mind.
14 CHAIR ROWLAND: Andy?
15 COMMISSIONER COHEN: Another wrinkle and there are so many.
16 Along with this idea of the sort of short-term and long-term vision recommendations being
17 interconnected, I also just want to reiterate a point, which is that while I think that aligning children's care in
18 this larger system of marketplace coverage, that we are building today and that is sort of built on some of
19 the principles of CHIP, is of value -- you know, the alignment is of value.
20 There are a lot of values there. I'm not necessarily saying that those values are greater than the value
21 of, if we -- you know, depending on what the studies show, the -- if they're significantly better benefits in
22 CHIP if the -- you know we know the cost sharing is quite different, etc., so I think we also, want to be
23 really careful about how we craft a recommendation if it goes along the lines that we've been discussing.
24 Where it's a conditional -- like it is something -- you know alignment or bringing you know sort of
25 CHIP under a marketplace umbrella -- you know, or however we want to sort of describe it, is of value and

1 something that we'd like to do, if there is a sense that children's coverage is not going to be you know
2 eroded in terms of -- you know, in general in terms of benefits, in terms of affordability and other things.
3 So those things I think also, have to be connected because I would -- you know, I would make a
4 different -- if you're saying take you know CHIP today and take all those kids and plunk them in the
5 exchange, today without any changes, I wouldn't be comfortable with that. So I just want to make sure we
6 make that interdependent.
7 The other thing that I do want to say and this is just a sort of personal -- you know an issue that
8 comes up all the time. I've never been very compelled by the evidence around the value of sort of keeping
9 families together. And that actually is not one of the reasons that I think that there should be alignment in
10 the marketplace.
11 I know there is some value to that, but it's never been -- seemed that strong to me, so personally, I
12 wouldn't say that is like one of the major reasons that we should do this. I think there are so many others.
13 But so far, everything that I have -- that we have discussed as a commission, I've felt like that is a very
14 wishy-washy -- I don't -- tell me what's the value?
15 CHAIR ROWLAND: The only thing I would say --
16 COMMISSIONER COHEN: They go to different doctors. Kids and adults go to different
17 doctors.
18 CHAIR ROWLAND: The only thing --
19 COMMISSIONER COHEN: The password. You know knowing a different password for -- if
20 you're able to get on the Internet you know managing two versus one like that's hard, but I --
21 CHAIR ROWLAND: But there is a lot of evidence that where parents are covered that children are
22 more likely to get --
23 COMMISSIONER COHEN: But that --
24 CHAIR ROWLAND: -- coverage.
25 COMMISSIONER COHEN: Agree, but that's not the same as saying that they have to be in the

1 same coverage.

2 VICE CHAIR SUNDWALL: It seems so counterintuitive to me that you'd say it doesn't matter.

3 As a parent or a grandparent, I can't imagine it wouldn't be better to have your children on your plan.

4 COMMISSIONER COHEN: I mean, we have discussed it and we've asked the question a few

5 times. You know we've asked it. We have asked the question to --

6 CHAIR ROWLAND: Norma?

7 COMMISSIONER COHEN: -- you know to people testifying, and two times I've just -- anyway,

8 my personal perspective that it's not -- it's not our strongest argument.

9 CHAIR ROWLAND: It might depend on how much paperwork you have to do, and how many

10 times you have to pay deductibles and co-sharing --

11 COMMISSIONER COHEN: Exactly.

12 CHAIR ROWLAND: -- and how you coordinate all that. Norma?

13 COMMISSIONER COHEN: It's not necessarily inherent.

14 COMMISSIONER MARTINEZ ROGERS: I think that speaking as a Latina, and that in our

15 culture -- and I mean, really I can't even think of any culture. But definitely in my culture I can address, is

16 that we would want the family to be together. I can't -- I could not imagine my children being -- well, now

17 they're men, but I know that their children are under their plan. I mean, I can't imagine.

18 COMMISSIONER COHEN: But that's what CHIP is. I mean --

19 FEMALE SPEAKER: But CHIP is separate.

20 COMMISSIONER MARTINEZ ROGERS: CHIP is separate.

21 COMMISSIONER COHEN: Right.

22 CHAIR ROWLAND: Robin?

23 COMMISSIONER MARTINEZ ROGERS: CHIP is separate.

24 COMMISSIONER SMITH: I think it's a provider network. I would want to make sure that my

25 kids were, if at all possible --

1 COMMISSIONER MARTINEZ ROGERS: If possible.

2 COMMISSIONER SMITH: -- I would prefer that my children be seeing the same providers that --

3 COMMISSIONER MARTINEZ ROGERS: Right.

4 COMMISSIONER SMITH: -- I am because --

5 COMMISSIONER MARTINEZ ROGERS: Me, too.

6 COMMISSIONER SMITH: -- it just makes --

7 COMMISSIONER COHEN: Most kids go to a pediatrician.

8 COMMISSIONER SMITH: In our case, Sam does not because he is very complicated and he has a
9 special pediatrician and a lot of specialists. However, my grandson is now going to one of his specialists so
10 you know and we picked him on purpose. So it --

11 CHAIR ROWLAND: I think what we're saying is that health care and health care insurance, even,
12 is a personal issue and different people --

13 MR. PETERSON: Right.

14 CHAIR ROWLAND: -- value it in different ways and want different choices. And Chris is not
15 responsible for deciding --

16 (Laughter.)

17 -- whether families should be together or not together on their policies. But what he is responsible
18 for is helping to guide us down this glide path we want to go.

19 And I think we've started and thrown out a lot of issues and ideas here, but what we're clearly
20 coming to a conclusion on, is that we want to envision the best way to have a seamless form of coverage
21 that includes adequate benefits and reasonable affordability for children throughout, beginning with
22 Medicaid and going up through the exchanges.

23 And we're just going to have to work on what the transitional steps are and what that means for
24 CHIP in the short-term and in the long-term. But I think the focus that we want is not on maintaining a
25 program, but on figuring out how it works best for families and for people.

1 MR. PETERSON: Yes.

2 CHAIR ROWLAND: And to really help us figure out what we want to do in our trajectory, is to try
3 and think of different scenarios and how different families would go through it. But for today, I'm going to
4 let Chris off the hot seat, and say we'll resume, of course, tomorrow with the Affordable Care Act, which is
5 also, very easy to deal with.

6 MR. PETERSON: Yes.

7 CHAIR ROWLAND: But I want to thank Chris for his presentation. We've given him a lot to
8 think about and the staff to work on, and to invite anyone who's followed this long day with us, to come to
9 the microphone for public comment.

10 Thank you.

11 MR. HALL: Hi.

12 **### PUBLIC COMMENT**

13 MR. HALL: Thanks so much. I'm Bob Hall. I'm staff for the American Academy of Pediatrics. I
14 really appreciate the opportunity to speak with you all today, and I want to thank you for all the work you're
15 doing to help vulnerable children across the United States.

16 AAP's 60,000 pediatricians, pediatric subspecialists, and pediatric surgical specialists are dedicated to
17 the health of all children. Your focus on the needs of children are appreciated by pediatricians.

18 Children will benefit if CHIP is reauthorized. If it's not, children will be worse off for four reasons
19 that are critical to the healthy development of the nation's future workforce. First is, benefits:

20 You discussed this today, but pediatricians know that children are not just little adults. The number
21 one killer of children in the United States is injury, not heart disease or cancer.

22 Pediatricians were polled in 1999 and 2007 regarding the highest priority in a health coverage
23 system, under which all children are insured, and their priority was clear: get benefits right.

24 Benefits and small business plans are not appropriate for children, whose care depends on
25 prevention, but as most recently due to the overwhelming success of immunization in the United States,

1 transition to prevention and care for chronic diseases like asthma, mental health conditions, obesity and
2 diabetes, as well as dental disease.
3 Historically, the average small business plan does not adequately cover these services. AAP
4 commissioned preliminarily analyses of state EHB decisions and found that CHIP has a clear advantage to
5 average small business plan in multiple areas. Medicaid, of course, contains the most robust benefit and
6 that's for a reason: EPSDT.
7 The Early and Periodic Screening, Diagnosis, and Treatment Program, exists based on the needs of
8 the U.S. military and the country as a whole. The President's Task Force on Manpower Conservation
9 produced in 1964 a landmark report: "One-Third of a Nation." This report showed that those who failed
10 the draft could have qualified if their preventive needs had been met.
11 The simple truth is that the future workforce of our nation, as well as our country's long-term
12 national security, depends on our children's health. CHIP's flexibility at least allows some states to choose
13 to fund EPSDT with CHIP dollars. That's why that flexibility is critical. EPSDT is an important bedrock
14 benefit for our future.
15 Network Adequacy. Children need different provider networks than adults do. To that earlier
16 question then discussion. We have seen in Washington State, the frustrating reality of marketplace plans
17 excluding Children's Hospitals from provider networks.
18 States have the responsibility to regulate provider networks, so we have not documented complaints
19 with provider networks in CHIP plans. Complaints regarding narrow networks in marketplace plans are
20 legion.
21 These networks matter even more significantly for children and youth with special health care needs
22 who, depending on the definition, live in at least one in five U.S. households. CHIP must continue so that
23 families can access the networks of pediatricians and specialists they need.
24 Actuarial Value. You've also discussed this. First Focus commissioned a study on the actuarial
25 value of CHIP plans at differing FPLs. It is clear that CHIP plans surpass even so-called "platinum plans"

1 in their value, out-of-pocket costs to the consumer. This was a Watson Wyatt 2010 study; you also saw
2 another study earlier today.
3 Finally, the fourth reason is really the kid glitch and affordability test, which you all have greatly
4 covered.
5 The last thing I'd say is that CHIP provides an opportunity for us to incentivize quality
6 improvement. In CHIPRA, Title IV was a quarter of a billion-dollar investment in pediatric quality
7 improvement that is not included in Medicare where hopefully something like that will go forward in
8 another CHIP reauthorization.
9 Thank you.
10 MS. BUIST: Hi. My name is Alison Buist. I'm the Director of Child Health at the Children's
11 Defense Fund, and I just want to thank you again for an excellent discussion. And I just have a couple of
12 very quick points.
13 The first is that -- and just to boil today's discussion down to be very simple -- I think our bottom
14 line is that under no circumstances should children lose benefits or cost sharing protections that they
15 currently have. And so this is really relevant to the discussion on the future of CHIP.
16 Based on the research that we have delved into that Chris presented here today, it appears pretty
17 clear that CHIP is going to be better for kids on both benefits and affordability, unless the exchange is
18 improved. And as we know, there are more reports coming out soon, but to my understanding very few of
19 them are actually comparing benefits and cost sharing. They're just basically looking at what they are, but
20 they're not laying out a marker of what comparability should be.
21 And I wanted to add something to the mix, and I'm sure you already know about this, but it wasn't
22 discussed today. That there is a requirement in the ACA that by April 2015, the Secretary must review
23 benefits for children and cost sharing in qualified health plans, and shall certify those plans that offer
24 benefits and impose cost sharing with respect to such benefits that the Secretary determines are at least
25 comparable to those in CHIP.

1 So it seems to us that the intent was pretty clear that children should not be moved from CHIP into
2 the exchange if those benefits and the cost sharing are not comparable. So how comparability can be
3 assessed in a way that is both administratively feasible and also meaningful for children and families has yet
4 to be determined. And again, the studies that are underway, I don't know how much side-by-side thinking
5 that has happened about that.
6 The CDF has developed some recommendations around this and we have shared these with some
7 folks at CMS. And we're happy to talk about these further as things move forward, but I think that this is
8 really critical that it moves forward so that we don't come to September 2015 and Congress is still sort of
9 sitting around saying, "What are we going to do about this?"
10 And then you know CHIP programs are closing down and what's happening to all these kids, you
11 know, on the ground. So we're really pleased that this thinking is starting up, and CDF is strongly
12 supportive of continuing CHIP funding until we can, you know, make sure that everything -- that again, the
13 children aren't losing benefits or cost-sharing protections that they have.
14 Thank you.
15 CHAIR ROWLAND: And we would welcome you to submit any of the recommendations that you
16 shared with CMS to the MACPAC staff for our consideration as well.
17 MS. BUIST: Thank you. I will.
18 MS. GARRO: Hello. My name is Nikki Garro, I'm Director of Public Policy Research for the
19 March of Dimes. Thank you for the opportunity to comment.
20 I just wanted to take a minute to call attention to coverage issues for pregnant women under CHIP.
21 This aspect of CHIP is often overlooked because it's considered a kid's program, but 19 states have used
22 this funding to cover pregnant women; I guess soon 18 that's what we learned this morning.
23 Given a number of factors, such as the challenges of affordability with the family glitch, CHIP could
24 provide a crucial safety net to ensure that pregnant women have access to prenatal and maternity care.
25 We commissioned a survey with NASHP of the 19 states who provide coverage to pregnant women

1 and some preliminary observations are that 14 states use the unborn child option; these are covering women
2 who would not otherwise be eligible for Medicaid, either. So it provides a very important safety net to
3 undocumented women and others that wouldn't be eligible.
4 Four states cover pregnant women and one, Rhode Island, uses both. For the states with the
5 unborn child option, there are variations in what services they provide to pregnant women. Some of them
6 don't provide any postpartum care.
7 With all of this in mind, we just urge the Commission to include issues related to pregnant women,
8 in your examination of the CHIP program and recommendations for changes in the future.
9 Thank you.
10 CHAIR ROWLAND: Thank you as well.
11 Any other comments?
12 (No response.)
13 CHAIR ROWLAND: Not hearing any, we thank our audience for both giving us comments, as
14 well as for staying with us through this day that I think has been most helpful in our ability to try and put
15 together our own thoughts and recommendations on children's coverage and the role of CHIP.
16 And we will adjourn now and reconvene tomorrow morning at 9:00 a.m., to take up the issue of
17 Medicaid interactions with exchanges. And obviously also, continue our discussion of coverage of children.
18 Thank you.
19 [Whereupon, at 4:24 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, November
20 15, 2013.]
21

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

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

Friday, November 15, 2013
9:00 a.m.

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

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

Session 5: Medicaid Interactions with the ACA: Issues and Analyses for Further Consideration

Chris Peterson, Director of Eligibility, Enrollment, and Benefits 148

Veronica Daher, Senior Analyst 164

Amy Bernstein, Senior Advisor 170

Moira Forbes, Director of Payment and Program Integrity 188

Session 6: Medicaid Non-DSH Supplemental Payments

Jim Teisl, Principal Analyst 199

Public Comment Day 2 212

Adjourn Day 2 215

P R O C E E D I N G S [9:24 a.m]

CHAIR ROWLAND: Welcome to day two of the MACPAC November meeting. Today we're going to shift our focus from the children's issues we covered yesterday to look more broadly at some of the Affordable Care Act issues. And especially looking at the interactions between Medicaid, CHIP and exchange coverage as they relate to eligibility enrollment benefits and other matters. We've asked two staff people, Chris Peterson and Veronica Daher to start off our discussion, and for the commission members we're now at Tab 6 of your briefing books.

SESSION 5: Medicaid Interactions with the ACA: Issues and Analyses for Further Consideration

* MR. PETERSON: Thank you, Diane. As you know open enrollment has begun for coverage that will be effective January 1, 2014 in all states for exchange coverage, and in about half the states that are implementing the Medicaid expansion. But even at this late hour the situation is dynamic in many states. Since our last meeting more states have announced they plan to implement the Medicaid expansion, and we will see how soon they can obtain federal approval and have those expansions implemented.

On the other hand, it is not breaking news that there have been problems with the federally facilitated exchange, or FFE, and Healthcare.gov. State based exchanges seem to be, well there's variation on how those are working. But rather than commenting on Healthcare.gov and how well it should work, your comments in our last meeting in September were that you wanted the Commission to focus on the policy issues, where your advice to the Congress would provide particular added value.

We had come to you in September with a long list of possible issues that could merit policy intervention, and asked for your guidance on which ones merited brining back for your consideration of options. Based on your feedback we have provided you in your Commissioner materials in Tab 6 papers that we will summarize today. As you saw with the CHIP materials, our presentations do not go over all of the information and evidence that are in the papers. Our presentations are on four specific issues that

1 pertain to the interaction of Medicaid and the ACA. Those four topics address churning among parents and
2 childless adults. Yesterday we talked about churning among children with respect to the CHIP and waiting
3 periods. Amy will be talking about churning with respect to pregnant women. So the first part is just
4 churning for parents and childless adults. The second is the self-only affordability test, third is pregnant
5 women, and fourth is concerns about the program integrity of eligibility determinations.
6 Your materials also include a paper summarizing projections of the characteristics of new Medicaid
7 enrollees. Those other issues we had talked about in September they're not going away. We will continue
8 to monitor implantation of the FFE, implementation of MAGI, the number and characteristics of new
9 enrollees, the extent to which states who cover adults above 138 percent of poverty may roll back their
10 eligibility levels, including to the disabled populations, and many other issues. We will likely describe those
11 issues in our March report, or may even bring them to you in future meetings. But in this presentation the
12 idea is to focus on those issues that may be amenable to solid recommendations by this Commission in
13 March.
14 So rather than going broad on all of those issues, we're going to dig deep on a handful of issues you
15 wanted us to delve into. So we look forward to your feedback on these particular options today. So the
16 presentations will be done looking at these options, I will be talking about churning among parents and
17 childless adults. Veronica will be talking about the self only test, otherwise known as the family glitch. And
18 there are a lot more words there on the screen if you want to be more precise. Pregnant women will be
19 talked about by Amy Bernstein. And then Moira will talk about the program integrity issues.
20 So for my part I'm going to review what churning is, our previous analyses and recommendations.
21 I'll talk about new churning estimates that we have among parents and childless adults, and then we'll talk
22 about options to reduce churning using potentially these policy interventions.
23 As a refresher on churning, when we say churning we're talking about individuals who are enrolling
24 and disenrolling in different sources of health insurance, or to no insurance, often in a relatively short
25 amount of time for small income changes, is one example. Yesterday we talked about CHIP waiting periods

1 is another way that churning occurs. Again, the Commission's focus is on intra year churning, churning that
2 takes place during the year. Not on changes at the regularly scheduled redetermination, which for most
3 populations will be annual. And just to recall, and this was talked about in the March report, the ACA is
4 making a lot of changes that are meant to address what we used to call, what we still call administrative
5 churning. So when people come to be re-determined they don't have the information they need. They have
6 to reapply and provide additional documentation. The ACA does many things to try to address this. And
7 we're not going to know the impact of those policies on administrative churning for some time. And so
8 that's why we're focusing on that intra year churning for now.

9 So without 12-month continuous eligibility enrollees must report income changes and may churn.
10 So as a reminder the Medicaid regulations say that if individuals have a change in their income or other
11 situation that may affect their eligibility they are required to report that.

12 For children states have the option to do 12-month continuous eligibility, which is to say the state
13 doesn't want to be bothered with that in the interim. At the redetermination that's where they will assess
14 any changes, and where families are at that point in time.

15 Our March 2013 report spent a great deal of time looking at the impact of churning. I'm not going
16 to rehash all of that. And we decided not to include that either in your materials. So that research has not
17 changed much. There is little that has come out in the interim, except for this last bullet. There was new
18 research that showed that the greatest churning in Medicaid is among non-disabled adults under age 65.
19 And so that is the parents and childless adults that I'll be talking about, and the pregnant women that Amy
20 will be talking about.

21 And as a reminder, in our March report we had two recommendations to the Congress regarding
22 churning. And here's the language that in order to ensure that current eligibility options remain available to
23 states in 2014 the Congress should, parallel to the existing Medicaid 12-month continuous eligibility option
24 for children, create a similar statutory option for children enrolled in CHIP, and adults enrolled in Medicaid.

25 In the interim since then, CMS has clarified that 12-month continuous eligibility, while it may not be

1 explicit in the statute, that states continue to have that flexibility, even past 2014. CMS also came out with
2 guidance that 12-month continuous eligibility is not a statutory option for adults in Medicaid. But that
3 states can apply for 1115 waivers to effectuate that. We had acknowledged in our March report that waivers
4 would be possible. But where good policy interventions are meritorious the Commission had said that is
5 better to have a state plan option, rather than require states to go through waivers.

6 Transitional medical assistance. And I'll spend some time talking more about that in the latter part
7 of this presentation. But that refers to parents and children who are the very lowest income parents and
8 children in Medicaid, who if their income changes they can remain enrolled in Medicaid for another 6 to 12
9 months. Our recommendation was that the Congress should permanently fund TMA, because as it stands
10 now Congress has to appropriate funds for that. And it's usually about every year or so. The funding for
11 TMA currently ends December 31st of this year. So we might see some action around that once more.
12 And the Commission also said that states who expand to the new adult group should be able to opt out of
13 TMA. So if those very lowest income parents their income goes up to the new adult group in an expansion
14 state, they will maintain their coverage. So to some extent churning is addressed by that continued
15 coverage.

16 But the Commission had also paired these recommendations on purpose in terms of the
17 Commission had talked about whether 12-month continuous eligibility really becomes a good substitute for
18 what was previously done through TMA. So that if parent's income changes under 12-month continuous
19 eligibility, that does not have to be reported. That they continue to be enrolled. And the Commission had
20 talked in prior meetings leading up to the March report about how 12-month continuous eligibility creates
21 an eligibility or an open season kind of look to it that is similar to employer sponsored coverage and
22 exchange coverage. So I just wanted to remind you of those discussions we had back then.

23 So I want to walk you through kind of a simplified example here of how churning can occur in 2014
24 in the current world. Taking, for example, a family of three in a state that implements the Medicaid
25 expansion. In a family at a 120 percent of poverty, so for a family of three is $23,500 per year. So you've

1 got the mom and dad and the teenager. And this is the status in January.

2 So let's say the father, for example, has a job that's seasonal and as the weather warms up he can
3 make a little more money. In April the family's at 140 percent of poverty. Assuming the state does not
4 have 12-month continuous eligibility he is required to report that change and that shifts their eligibility. The
5 child then would churn into CHIP coverage in this example. And the parents it's not always clear what
6 would happen. They may be eligible for exchange coverage. They may not be eligible if the self only
7 affordability test applies. Even if they are eligible for exchange coverage they will still have to pay some
8 premiums generally. And so even if eligible they may not enroll. They may be offered employee sponsored
9 coverage, which they may take up. So it's really unclear how this would play out for this family. Which is
10 why they're on that dividing line there.

11 In July mom reports that she is pregnant. What that means is that for her the unborn child counts
12 as an additional family member, which even at the same income level her FPL drops to 116 percent of
13 poverty. The state can choose to have that also occur for the dad and the daughter, but they may not. And
14 for this example we'll just stick with 140 percent of poverty. So the mom could change. And Amy is going
15 to talk about this a little more, so you can talk with her more about that in her session. I'll just get your ire
16 up on the examples. So she is supposed to, as it were, raise her hand and report that she is pregnant. And
17 therefore in this example move to Medicaid. But if she does not and she continues in exchange coverage,
18 for example, there is no penalty for doing that. She does not have to repay the tax credits, for example. So
19 it is not clear where the mother would end up in this scenario.

20 Then let's say the dad's income drops as the weather cools off and falls back to 120 percent of
21 poverty, then they family could report this income change and all go back to Medicaid. And just for another
22 example, if the state had 12-month continuous eligibility, then those income changes would not be reported
23 and the family would remain in Medicaid for that duration. But there are considerations that 12-month
24 continuous eligibility brings, of course. Where the child, for example, as the child moves from Medicaid to
25 CHIP, that also means the child is moving from the regular matching rate for Medicaid to enhanced

1 matching under CHIP. So there are considerations. Are the mom and the dad are they in the newly eligible
2 group so that they're getting 100 percent match? Or if the state had already expanded to 120 percent of
3 poverty maybe they were getting the regular match. Moving to exchange coverage is, of course, 100 percent
4 federally subsidized. So there are many things to think about in terms of the implications on states.
5 So one of the questions that we had is if we look at parents and childless adults who are below 138
6 percent of poverty, and let me just say childless adults is shorthand for non-disabled, non-aged, non-
7 pregnant adults without dependent children living in the home. So that's what I mean when I say childless
8 adults. So as we look at an individual, parents and childless adults who start below 138 percent of poverty,
9 what is their income after four months? And you see here that the vast majority remain below 138 percent
10 of poverty. But there are some income changes. At eight months there are some more income changes.
11 And then at 12 months additional income changes. And this, of course, at 12 months would be the time for
12 the regular redetermination.
13 So putting it all on one slide then you see four months. Let's just go with all of the non-elderly
14 adults at 4 months 23 percent would have that income change going above, 28 percent at 8 months, and 32
15 percent at 12 months. So one of the questions that 12-month continuous eligibility raises is, is it worth
16 having the parents and childless adults report those changes at 4 and 8 months, if many of those will go out
17 at the regular redetermination? So it's about the tradeoffs of that kind of assessment. And it's also a
18 question of how many of the parents and childless will raise their hand and report those changes at four and
19 eight months?
20 CHAIR ROWLAND: And, Chris, we don't know how large those changes are though. I mean is
21 someone going over by $50 or going over by $5?
22 MR. PETERSON: Well, the previous slides were an attempt to capture that in terms of how many
23 how are going up to exchange eligibility levels versus above the exchange eligibility, subsidized exchange
24 level of 400 percent of poverty. We got from Brett Fried from SHADAC these analyses. And so this was
25 one way to try to capture the magnitude of those changes.

1 CHAIR ROWLAND: I presume that the people who go over are the people at the top of the
2 income, they're closer to 138 then. There's not a lot of change for people who are 50 percent of poverty.
3 MR. PETERSON: I think that's right. And we'll see that in a slide coming up in a little bit.
4 COMMISSIONER COHEN: Is it okay to ask sort of factual questions about this stuff now? Can
5 you talk a little bit. I know so much about compliance with the rule about reporting. Maybe you can tell us
6 what we do know. And is there a federal standard for what the consequences are supposed to be if you
7 don't report?
8 MR. PETERSON: Honestly, I've gotten a lot of different answers on your first question. The
9 extent to which people really do report changes. On the one hand I've heard people have a lot going on
10 and reporting a change to the Medicaid agency is not a top priority for them with their children and the
11 things going on in their lives, these lower income people. On the other hand I've heard that the applications
12 for Medicaid make it very clear that people are supposed to do this, and there could be consequences
13 involved. But what those consequences are, we'd have to get back to you and talk a little bit more about in
14 the real world how that exists. But I think in the real world I'm not sure there are many that are used often.
15 CHAIR ROWLAND: And I'm assuming there's standard way that even notification is done,
16 probably one way in one state and one way in another state. And do we have any sense of whether it's hard
17 or easy?
18 MR. PETERSON: Yeah, we could talk more with some states about these issues and circle back.
19 CHAIR ROWLAND: Just to add to that. And the administrative issues around that, cost and
20 burden. I'm assuming if it's hard to do it's because it's expensive to make it easy to do.
21 MR. PETERSON: To report the changes?
22 CHAIR ROWLAND: Yes.
23 MR. PETERSON: Yeah. But remember the state, there's a cost associated with 12-month
24 continuous eligibility as well as you keep people enrolled in the program. So it's a tradeoff.
25 CHAIR ROWLAND: But there also may be state administrative savings doing 12-month eligibility

1 in addition to the extra cost for keeping people on the rolls longer than they would've been on.

2 MR. PETERSON: Yes, that's right. And we have tried to describe that in the March report and

3 raise those kind of tradeoffs.

4 VICE CHAIR SUNDWALL: Just a little fact that in Utah when we passed that recommendation I

5 was surprised that there was not any celebration about that. And they'd run their cost data and estimated it

6 would be 20 million more a year in state cost. I don't know if that's overly estimated, but still it would've

7 been perceived as a burden in that state.

8 MR. PETERSON: Before I cover up the legend, and I'm sorry that it works out like this, hopefully

9 it shows up on your slides okay. So the blue numbers are going to show your 1931 levels for parents before

10 we add in the new adult group. So just a reminder, 1931 is how low income parents and children are

11 covered in states today. Particularly for parents is what we usually think of for 1931 coverage. And it varies

12 by state. So this is an area that prior to the ACA states were, as you see, kind of all over the place in how

13 they cover parents. Ranging from the teens as a percentage of poverty to and above 133 percent of poverty.

14 So what it means TMA is for these parents whose income increase, they will have extended coverage under

15 current law. The new adult group for parents comes in, in the states that are implementing the expansion,

16 and so it goes up to a 133 percent of poverty for those states. But I do this to illustrate that in the

17 expansion states some parents will be eligible for TMA because they're covered under 1931, and others will

18 not.

19 Diane, I think this makes the point that you were talking about earlier. It's kind of a different way to

20 do it about the level of churning from relatively small changes. What this is trying to show is that if you're

21 looking at Arkansas that's TMA, that's 1931 level is at 10 or 20 percent of poverty, it's much more likely that

22 income will change in such a way that those folks are going to churn. So those states that are not

23 implementing the expansion to parents, for example, they see a lot more churning than those if you made

24 kind of a broader eligibility coverage area for parents.

25 So some options for your consideration regarding churning. So the first set has to do with 12-

1 month continuous eligibility. We could restate the March 2013 recommendation that Congress should
2 provide explicit 12-month continuous eligibility option for adults in Medicaid and children in CHIP.
3 And then you could require it for certain populations. For example, for parents or for childless
4 adults, or for children, or for all populations. So there are the set of continuous eligibility options we
5 wanted to bring to you.
6 Then there are options around TMA. And again, we could restate the 2013 recommendation that
7 Congress should permanently fund it and then allow states to opt out if they expand to the new adult group.
8 The second option here is to more explicitly pair the TMA recommendation with continuous eligibility. So
9 one is the same that Congress should permanently fund it, but to allow states to opt out of TMA if they
10 expand to the new adult group and if they implement 12-month continuous eligibility for affected
11 individuals.
12 And then there are other potential options that you could consider. One has to do with premium
13 assistance, which was talked about yesterday. An option could say Congress should create a new statutory
14 pathway for implementing exchange based premium assistance through which states could mandatorily
15 enroll parents and childless adults. So on the one hand there is a statutory option for states to use premium
16 assistance for exchange coverage. But it is limited in such a way that states cannot require parents and
17 childless adults to enroll in it. That states must enable enrollees to have a choice of plans. And as a result of
18 that the states who are doing premium assistance are having to use waivers. So the state plan option is
19 there. But by in large for exchange coverage they are not using it. So the question is should there be a
20 statutory pathway so waivers are not required, or on the flip side do we really not know enough about how
21 these enrollees are going to fair under exchange based premium assistance, and so maybe that's not an
22 option that should be considered at this point, until we know more information.
23 With respect to bridge plans, bridge plans refer to the ability, for example, of an exchange plan to
24 cover some individuals in Medicaid. That is in this case generally the way we think of bridge plans is the
25 QHP, the exchange plan will only cover the family members of the Medicaid and CHIP eligible family

1 members of those QHP enrollees. At this point only state based exchanges are permitted to use bridge
2 plans. The FFE does not have that capacity at this point. It does not appear there is broad state interest in
3 doing this.

4 I know that Washington State is doing it. They put out an RFP for plans to see if they would like to
5 be a bridge plan. And the last we heard was that among all of their QHP plans only one they thought was
6 even going to apply for this opportunity. And the issue is that if you are a QHP who wants to be a bridge
7 plan in the exchange coverage, you still have to be certified as a Medicaid managed care organization. So
8 they still have to jump through all the hoops. So a consideration is should they have to jump through all the
9 hoops versus some of the other tradeoffs around this issue.

10 So that concludes my portion of the presentation on the churning related issues.

11 COMMISSIONER RILEY: Really nice job. Churning made simple sort of. I was not fully
12 comfortable with our recommendation last time. Because I think it's tough to look at the churning issue
13 from a Medicaid lens only, since it's churning between the exchange and Medicaid. And so when you think
14 about 12-month continuous eligibility it's a savings to exchanges, which is 100 percent federally funded.
15 Often, not always. So I'd be more comfortable in an approach that looked at both. And I know that's a
16 little bit beyond our charge. I wanted to ask if you could, in the paper you talked about the CBO estimates.
17 And it seems to me that there's tradeoffs here. Because you can't look at the CBO estimate only for
18 Medicaid, because there are savings on the exchange side and they move back and forth between those. So
19 I would feel more comfortable with recommendations that dealt with both sides. Because I think otherwise
20 you've created some curious disincentives or strange incentives if you only deal with one side of the coin.
21 But I'd like to know more about the CBO, what those CBO estimates were.

22 MR. PETERSON: So two things. One is that for exchange coverage, setting aside our scope at
23 MACPAC, is that individuals are required to pay premiums for that and they get tax credits. And there is a
24 reconciliation for exchange enrollees that happens once they file their taxes. So in the exchange context it's
25 quite different. And I'm not sure how a recommendation to the exchange coverage would work with

1 respect to what people say their income will be, how it ends up playing out, and how that reconciliation then
2 happens, on their premium tax credits takes place. So that's more complexity, obviously, pulling that side of
3 things.
4 On the CBO cost estimate I'm trying to recall. It seems to me giving the option did not, because we
5 had this in our March report, and it seems to me the costs were fairly negligible. And I think this goes back
6 kind of to the conversation we had yesterday in terms of 12-month continuous eligibility is keeping people
7 enrolled in federally subsidized coverage, but they were going to federally subsidize coverage anyway.
8 Whether it's to the new adult group, if they were coming out of TMA, for example, or they were going to
9 exchange coverage. So the implication on the federal government, particularly in terms of the buckets in
10 which CBO gives us their cost estimates, is relatively small. If, of course, you did mandatory 12-month
11 continuous eligibility for populations, that's where you start talking some federal money. Several billion
12 dollars I think is what was in the March report, if I recall correctly. Because we had at least ran that by
13 CBO. We have not at this point asked them for cost estimates this time around. We're waiting for your
14 feedback from this meeting to do that. And so we don't know yet the extent to which that will change at all.
15 COMMISSIONER RILEY: My concern, and certainly it's 100 percent federally funded for the
16 newly eligible, but my concern is equity issue. That why ask to have to pay 100 percent continuous eligibility
17 to lock somebody in for 12 months when it's a savings to the exchange. So it's the issue of who should pay.
18 MR. PETERSON: So then you wouldn't be comfortable with requiring 12-month continuous
19 eligibility, but if states want to have that option, then that option should be available.
20 COMMISSIONER RILEY: I'd be comfortable requiring it if the federal government paid for it
21 through the exchange financing. That'd be easy.
22 CHAIR ROWLAND: For a substantial share of it the federal government is paying for it on both
23 sides of the equation.
24 COMMISSIONER RILEY: But it still makes sense (inaudible).
25 MR. PETERSON: I think one of the key distinctions is the state expenditure. The state certainly

1 doesn't have to pay when people go to exchange coverage. So that, again, gets to a difference between do
2 you have it as an option that's available, versus requiring it. Because requiring it you're certainly requiring
3 additional state expenditures.
4 COMMISSIONER COHEN: Maybe just restating sort of the obvious. But it seems to me this
5 issue touches on a number of things that we have opined on as a commission. And that are about its sort of
6 alignment with the principles of health reform and the principles that we've talked about. Churn that results
7 in periods of uninsurance is bad. Coverage generally is better for people, it's now more or less a national
8 policy. And churn between programs that interrupts courses of care makes people fall through the cracks
9 because of the complications of finding new providers and other things is bad. But there's also a principle
10 that contributions to healthcare should be income related. And that that's in the ACA that there should be
11 sort of a sliding scale. So I think, and again, I may be just restating the obvious, this is clearly the idea that
12 there are large numbers of people who could churn. They could churn off by accident easily. So they could
13 churn into uninsurance even though they're eligible for something in the exchange.
14 And they could churn between plans and not get optimal care is a really serious problem. And I
15 think what we're really struggling with is the solution in the sort of limited toolbox that doesn't impose costs
16 unnecessarily on the state or the federal government. So I mean I think that's our challenge is to sort of
17 figure out where the cost should lie. And we're also doing this without full information about how many
18 people actually report what the costs are, what the burden is to do this work of having people go from one
19 program to another, or on a program and then off and then on again, where there might be pent up sort of
20 demand for services, or conditions have progressed. So it's a real challenge.
21 And I guess all I'm really sort of trying to say is it seems to me that the issue, it sort of just boils
22 down to a who pays and how do you structure that in the confines of how the ACA works and Medicaid
23 works. Ideally someday we're on a system where there's sort of more fluidity and there is a way in Medicaid
24 to say if your income went up there is some way to say make a small and appropriate contribution during
25 the year. But I think that takes a lot of creativity to build that system. I'm not sure we're quite ready to sort

1 of make a recommendation around that now. Personally I would see that as sort of the end game
2 ultimately.
3 CHAIR ROWLAND: But there is no objection around this table to continuing the
4 recommendation we made in our March report that states should have the option to do this for CHIP
5 children and for adults in Medicaid. And then to reiterate to try and get more information on what the, you
6 know, I think the way you've laid out this flow is an important contribution to being able to say, but these
7 are some of the disruptions. Here's how continuous eligibility could smooth it out. But here are some of
8 the glitches. So I think the material presented here would be informative as helping to underscore a
9 recommendation. But to get more of the administrative and the cost of if all states were doing continuous
10 eligibility what would it be, so that we have some magnitude of what we're looking at as a cost issue. Is that
11 the agreement of the Commission? Now, we'll move on then to Veronica.
12 MR. PETERSON: Should we talk about the TMA then and walk through whether it's a restatement
13 of the 2013 recommendation, or whether it should add to it that states would only be allowed out of TMA if
14 they implement 12-month continuous eligibility.
15 VICE CHAIR SUNDWALL: Just for my clarification. Would TMA still be necessary if we had 12-
16 month continuous enrollment?
17 CHAIR ROWLAND: No.
18 MR. PETERSON: I think the answer is no in the expansion states. So that's why this option would
19 say if you're a state that has expanded to the new adult group, so that you've got coverage for parents all the
20 way up to 400 percent of poverty, either through Medicaid or exchange coverage, and you implement 12-
21 month continuous eligibility, then you've done what you can do to prevent churning. But TMA does need
22 to remain for the states that are not doing the expansion, because if you're at 20 percent of poverty and
23 that's all you're covering for parents right now, and those parents churn to 50 percent of poverty, there's no
24 Medicaid expansion for them to go to. So TMA would need to remain available to prevent uninsurance
25 there. And that's why the first part of both of these recommendation is identical to say Congress shouldn't

1 have to tinker with this every year and should just permanently fund it.

2 CHAIR ROWLAND: But I think our first recommendation should stand. We've said that

3 Congress should permanently fund it, and we'll see what Congress does with that coming December. And

4 then allowing the states that expand to opt out. But that keeps it in place for the states that don't.

5 COMMISSIONER SMITH: So in a perfect world if all states eventually expanded Medicaid and we

6 tell them to permanently fund TMA, wouldn't that conflict with each other?

7 MR. PETERSON: Well, I think there would be a reassessment at that point.

8 COMMISSIONER SMITH: Or can you permanently fund it at one dollar or what?

9 MR. PETERSON: I think if every state were then to implement the Medicaid expansion, then it

10 would call into question whether TMA is necessary, number one, and whether 1931 as a separate pathway is

11 necessary at all. And I think that is also a conversation that will occur with respect to pregnant women,

12 where as to Medicaid Congress makes interventions and adds things on, whether it's parents coverage or

13 pregnant women coverage: At what point do you say having four pathways doesn't make sense? One is all

14 that's necessary. We'd actually talked about only having one pathway for adults, to do away with 1931

15 before the Supreme Court made their decision. Once the Supreme Court said you don't have to do this,

16 then that changed the conversation. And then there were these other options. I don't know whether

17 there's interest in these.

18 CHAIR ROWLAND: I think at this point -- Sharon.

19 COMMISSIONER CARTE: I'd just like to ask Chris a question. If the Congress were to create a

20 new pathway for premium assistance, would that involve also making changes to ERISA on your opinion?

21 MR. PETERSON: No. Because we're not talking about anything having to do with employer

22 sponsored coverage. We're not talking about the premium assistance that states use to purchase employer

23 sponsored coverage. This is specifically referring to exchange based premium assistance, like Arkansas is

24 doing, where individuals are eligible for Medicaid and use Medicaid dollars to purchase exchange coverage.

25 COMMISSIONER CARTE: But if part of that -- okay, so it would just be through the exchanges.

1 I'm trying to think. I'm in a state where we have a lot of self-funded employers. That they would be sitting
2 separately outside the exchange.
3 MR. PETERSON: Right.
4 COMMISSIONER CARTE: But still --
5 CHAIR ROWLAND: There's already an option for premium systems there.
6 COMMISSIONER CARTE: I don't know, I have to think about that.
7 CHAIR ROWLAND: Well, clearly the Arkansas experience is a demonstration from which we
8 hopefully will learn how this works. But as we discussed yesterday, we need to look more broadly at how to
9 move people from public coverage through Medicaid, as well as through CHIP, into exchange based
10 coverage. So I think looking at options of how to make that glide path work is something that the
11 Commission ought to explore. But a specific recommendation of how to do it I think is premature.
12 But I do think that one of our charges ought to be how do we make this seamless coverage and
13 what are the different strategies that may or may not be in the statute at this point to smooth that transition
14 between. And that'll help address some of Trish's issues about when does someone get shifted, and what
15 monies go with or without that individual.
16 COMMISSIONER RILEY: This recommendation seems premature, given 1115s are supposed to
17 be research and demonstration. And we have a live one with Arkansas. But it may be appropriate to think
18 about asking the Secretary and CMS for regular reports about that Arkansas demonstration and see if we
19 can learning quickly. And maybe expedite if there are findings early, expedite a process whereby CMS could
20 do more of that. But I think we really have to be true to the 1115 R&D function and let it play out a little
21 bit.
22 CHAIR ROWLAND: Andy, and then Richard and then Donna.
23 COMMISSIONER COHEN: Another way of looking at this issue, besides the sort of the very
24 specific kind of how do we address churning of one person moving from 122 percent of the poverty level to
25 142 percent of the poverty level in a year. A larger issue that goes to sort of alignment is that exchange

1 coverage is based on, is a year, and Medicaid coverage is monthly. And the exchange looks at a person's
2 whole year experience and then says if our projection turns out to be wrong we're going to pull back some,
3 you know, we're going to ask you for money back in a subsidy. We are going to be watching how that goes.
4 There is concern around that and how people actually manage to that possibility.
5 But it is a very different kind of framework than Medicaid, which says you're eligible for a month, by
6 month, by month. So there's continuous eligibility as a possibility. Which again only goes to income
7 changes, it doesn't go to status changes, I think, if I understand that correctly. If you turn 18 in the middle
8 of the year, or 19, or get pregnant it doesn't go to those things. But sort of looking more broadly at whether
9 or not we should be looking at Medicaid as something that, again, should be sort of like an annual look.
10 And again, with the option, and I keep sort of pushing this idea, with an option that has to be sensitive to
11 these are very low income people. For at the end of the year if the average is somewhere or another that
12 there might be an opportunity for a personal contribution that wouldn't exist if you stayed below the limits
13 at all times. Anyway, it is just something for sort of a bigger picture look at how these two programs that
14 are supposed to match up to each other really are so different and try to align them in a slightly more macro
15 way, than just saying require continuous eligibility.
16 COMMISSIONER CHAMBERS: A question and a comment. So the question on this one with
17 the bridge plans, I was reading and I was thinking that the bridge concept of allowing QHPs to enroll
18 Medicaid and CHIP eligible family members in their plans, whereas most of the states have discussed bridge
19 plans as where it's Medicaid and CHIP plans is to allow to continue. So this is just a variation on the theme
20 as opposed to this is the bridge policy then.
21 MR. PETERSON: Right. So it could work either way.
22 COMMISSIONER CHAMBERS: Good. And then I guess I just don't know the answer. Your
23 slide that talked about the over 12-month period as the churning, and it was back on slide 14. It was the
24 one that had the -- and it shows over 12 months. Yes, this one here. So four months it's around about a
25 quarter. And you get up to 12 months and it's around a third. So is that just a percentage that churn once?

1 And I'm just curious, how many people, what's the frequency of churning back and forth, or do people
2 generally churn once and stay in that sort of category for some period of time, or is there a lot of
3 fluctuation?

4 MR. PETERSON: And that's a question that we've asked in follow up. So we'll be able to circle
5 back to you as we get that information.

6 COMMISSIONER CHAMBERS: Good, thanks.

7 COMMISSIONER CHECKETT: Well, I certainly do agree, Diane, that we're not ready for this
8 level of recommendations. But I would like to see as we follow the 1115 waivers and the premium
9 assistance, and there will be other states as well, Ohio, Michigan, Iowa, Pennsylvania are all looking that as a
10 way of making their Medicaid expansion happen. It would certainly be of value to have those Medicaid
11 directors also come in and talk to us, as well as getting CMS updates. And I also think that we would all be
12 well served to as we look at bridge plan options, if we do that, to really have a very thorough understanding
13 of how the QHPs work, how they function and what that means to be a QHP. What does it mean to get on
14 an exchange? Because it is a very different process than being a Medicaid managed care plan.

15 And I sometimes think there's not full enough appreciation of that difference when we talk about
16 bridge plans. And I know Richard, I think you'd have ton to contribute with what you're doing in California
17 in particular, probably one of the only states that actually launched bridge plans. So, but a great and
18 important area for us to continue to explore.

19 CHAIR ROWLAND: So lots more to do on this issue. We'll be churning, and churning and
20 churning through these issues. But we're going to turn now to the family glitch, otherwise known as the
21 self-only test in insurance affordability under the ACA. Veronica.

22 * MS. DAHER: Thank you. So we did touch on this a little bit yesterday also. I'm going to
23 be talking about the self-only test, which is what we're calling it. A lot of people are calling it the family
24 glitch, or the kid glitch. So as you already know, under the ACA, people who are between 100 and 400
25 percent FPL can get subsidized coverage on the exchanges. But if they have access to affordable insurance

1 they are not eligible for those subsidies. So ESI has considered affordable for a family, if the employee's
2 contribution for self-only coverage does not exceed 9.5 percent of income. So that means that family
3 members up to 400 percent FPL who are not eligible for Medicaid or CHIP, whose ESI premiums cost
4 more than 9.5 of household income are ineligible for exchange subsidies.
5 Generally those who don't purchase insurance, or who reject an offer of affordable insurance are
6 subject to what's called a shared responsibility payment, which is assessed through the federal tax return.
7 We do want to note that individuals affected by this self-only affordability test are exempt from the penalty,
8 but that still means that they don't get any help paying for their insurance, so they'll be on their own.
9 The number of people that are affected by this, GAO estimates that about 1.9 children who right
10 now are eligible for CHIP also have an affordable offer of ESI. And then in the paper we gave some
11 estimates about people who churn. But right now we have some preliminary MEPS results, which indicate
12 that approximately 11.5 million children and adults below 400 percent FPL who are not eligible for
13 Medicaid and CHIP are also going to be ineligible for exchange subsidies due to an affordable offer of ESI.
14 And that number is made up 5.3 percent of about 57 million children, 8.5 percent of about 48 million
15 parents or caretakers, and 7.5 percent of about 61 million other adults.
16 Another preliminary number that we have is that about 72.3 percent of the 7.8 million parents who
17 are below 400 percent FPL, who are not eligible for any insurance affordability program do have a child
18 who's eligible for either Medicaid or CHIP.
19 So looking at this chart my point here is that the self-only test is going to be a high bar for insurance
20 affordability. So looking at the lines in red we're taking a hypothetical family of three. And this chart shows
21 that average employee contribution for self-only coverage is deemed affordable, even at 100 percent FPL.
22 Where you see that for the individual that's about five percent of income. Meanwhile, average contributions
23 for family coverage only fall below 9.5 percent of income when you get above 246 FPL, which is the second
24 red line. So these families who are between 100 and 246 percent FPL who are not Medicaid eligible may be
25 unable to afford their ESI premiums, but they're not going to qualify for exchange subsidies. So it's

1 important to note that these are average employee contributions.

2 On this next chart we have the percentiles. So looking at the line in red at the bottom we have the
3 annual ESI contribution that's at the 90th percentile for single coverage, and it's $2,200 a year. And even
4 that number would be deemed affordable for our same family of three if they're at 138 FPL.

5 So taking all those factors into consideration, some people have called for a reinterpretation of the
6 ACA affordability language, so that the cost of the coverage for the entire family would be considered in
7 this affordability calculation. But the finally Treasury rule was adopted without changing that calculation.
8 And so while the self-only test is not a Medicaid or CHIP issue, per se, a potential remedy does involve
9 Medicaid.

10 So it seems particularly relevant to this Commission. In light of these facts, the policy option that
11 we are presenting is an extension of Medicaid and CHIP to those who are affected by this calculation.
12 Now, if this was accomplished through a state plan, the state would have to offer Medicaid and CHIP to all
13 within that income level. This could cause crowd out where people may choose to drop private insurance
14 that they have access to and take up public coverage instead.

15 So another way to do this would be offering this coverage to a narrower group of people through an
16 1115 waiver. One issue with the waiver is that it's quite narrow, only to people who are affected by the
17 family glitch. So CMS has approved a targeted waiver, an 1115 waiver in Indiana, which extended Medicaid
18 to adults under 200 percent FPL who had not had access to ESI for at least six months. So if CMS
19 considers people whose family ESI costs more that 9.5 percent of income to be similar to that Indiana
20 group, then this could be a successful approach. But two important caveats regarding waivers are that they
21 must be budget neutral, and they can't cover people at higher incomes without also covering people at lower
22 incomes.

23 So in addition, states that did not choose to expand Medicaid would be unlikely to choose this
24 option, because they would have to effectively expand Medicaid up to 100 percent FPL and beyond to take
25 advantage of it. And they have already decided that they don't want to do that. Staff looks forward to your

1 input on these options and any other options that may merit additional analyses.

2 COMMISSIONER RILEY: Good thing everything's clear. Thank you for that. It seems to me
3 there's sort of another layer of analyses here. And there's two groups of people. One are, and I'm looking
4 at chart, maybe I'm looking at chart six, there are the people who are under 138. And if we assume the
5 family member who's employed only buys for self, that the family could go into Medicaid; correct? I'm a
6 low income person, I have ESI, but I only buy it for myself. My dependents are then eligible for Medicaid.
7 So that would invite some new thinking about premium assistance through Medicaid to allow that family to
8 have affordable family coverage. It seems to me that's a set of issues we might examine.

9 And for the higher income people we might think about the basic health plan and how that could be
10 structured as a remedy around the self-only problem. In other words, rather than address head-on the self-
11 only issue, because we know that's hugely involved with the financing of this program, could we think
12 differently about let the employee buy ESI. Family gets a premium assistance kind of thing to buy in. For
13 higher income people the basic health plan gets restructured and somehow can pay for maybe premium
14 assistance for that higher income group. But it just seems to me there's a set of analyses that could help us
15 think this through that we ought to look at.

16 CHAIR ROWLAND: Let's clarify kind of how this works with regard to Medicaid versus the
17 subsidies and the exchange. If you have an offer and you are very low income, you can still go into
18 Medicaid, as long as you meet the Medicaid income levels. So Medicaid does not have this bar that the
19 subsidies in the exchange do, which is that you can't get them if you have an affordable offer. So the issue
20 here is really access to coverage through the exchange, not access to coverage in Medicaid.

21 MS. DAHER: Right, that's correct.

22 CHAIR ROWLAND: But the problem that it's created is that it is intensely worse in states that
23 have elected not to expand, because the door to Medicaid is so much lower, for adults at least. David.

24 VICE CHAIR SUNDWALL: I'm not sure this is related, but I keep think of our discussion
25 yesterday where we wanted to allow public dollars to be used to purchase private insurance if they could.

1 And I'm not sure if that's part of what we're talking about here. But if families, if you did have an
2 affordable offer that didn't cover your children, but your children would qualify if they could get on that
3 family health plan, that would help address part of this, I think.

4 MS. DAHER: Yeah, I think that's something to be discussed also.

5 COMMISSIONER HENNING: But I think the biggest problem with the family glitch is that your
6 employer typically subsidizes the employee, so the cost to the employee doesn't meet that affordability test.
7 So in other words, you have affordable coverage, but it doesn't take into account the fact that your employer
8 also offers family coverage that is not affordable, that's not subsidized. And that puts that income level way
9 above what this particular family can afford. And yet you're not allowed to buy coverage on the exchange
10 for your children. And depending on the state you're in, if it's a couple and only one of them is working,
11 and you don't have children. So say the wife is working, she's got insurance, she wants insurance for her
12 husband. In Florida you couldn't buy insurance for him through the exchange, unless you basically were
13 above 138 percent of poverty. If you're under 138 percent of poverty you're out of luck, because he doesn't
14 qualify for Medicaid, and you can't buy exchange coverage.

15 COMMISSIONER CHECKETT: Do we have any idea how many people are affected by this?

16 MS. DAHER: Yeah, we're working on getting numbers. The numbers that I gave you were
17 preliminary, but we have some analyses going on that we -- I don't know, Chris, if you have a timeline.

18 MR. PETERSON: The 11.5 million really is the number.

19 MS. DAHER: Right, and those are preliminary right now.

20 COMMISSIONER CHECKETT: I see.

21 CHAIR ROWLAND: Is that everyone below 400 or between 138 and 400?

22 MS. DAHER: This is, so I believe it's 100 to 400 percent. And this scenario was taking states at
23 whatever decision they have made about expansion right now. So taking the current expansion decision. So
24 for some states I guess it would be up to 100 percent. People at 100 percent could buy in the exchange if it
25 was not an expansion state. But if it's an expansion state it would be 138 percent. But this takes into

1 account whatever decision the state has made.

2 COMMISSIONER CHECKETT: And these individuals are currently uninsured or just currently

3 getting coverage through their employer?

4 MS. DAHER: I think this is just the total population in that income range. Are you saying do they

5 actually -- I don't think we know what they actually have, but this is what they're eligible for.

6 COMMISSIONER CHECKETT: Right, I think that was more to what I was going to, is to what is

7 that number really, really going to look like. But I appreciate, this is a good start on it.

8 CHAIR ROWLAND: Richard.

9 COMMISSIONER CHAMBERS: Could I just get a clarification of what Denise said. After I

10 thought about what you said. So the example of the Florida couple and the husband, it's not that the

11 husband can't purchase insurance, just isn't eligible for subsidies; is that correct? So if it's over 138 percent,

12 so the wife has access to subsidized employer coverage, but for the dependent being the husband

13 unemployed you have to pay 100 percent of the premium, which usually is unaffordable, right. So it's not

14 that the husband can't purchase insurance in the exchange, it's just that he is ineligible for subsidies; is that

15 correct?

16 MS. DAHER: Right, that's correct.

17 COMMISSIONER CHAMBERS: Because I thought you said he's ineligible for purchasing

18 insurance. I was just going to say, no, there is access. It still may not be affordable, because there is no

19 subsidy. But I just wanted to clarify that to make sure I understood.

20 COMMISSIONER MARTINEZ-ROGERS: I'm from the great state of Texas. In Texas state

21 employees get their insurance paid for. Unfortunately housekeepers, because a family plan is so expensive,

22 can't afford, or staff who don't make a lot of money can't afford to get their kids covered. But there's this

23 stigma about putting their kids on CHIP. So they go into this program which is called, this is just FYI type

24 stuff, they go into this program that is called Care Link, which the county hospital offers. And it's based on

25 your income as to how much you pay for medical care or outpatient care. But the problem is you can only

1 use it there. So if they go someplace else or in another section outside of Bear County it doesn't cover
2 anything. And that is a real, real big problem. Because when I keep talking about ACA and getting on it
3 they can't even afford that.
4 CHAIR ROWLAND: This is an area where a lot more information would help inform our
5 discussion in terms of whether these individuals now take up employer based coverage, even though it is
6 unaffordable for them, or how many are uninsured and don't take up the offer, and really much more about
7 where their income ranges are. Because employers do subsidize family coverage, so some of the family
8 coverage is also subsidized. It's just not a subsidy high enough to help low income people. But I think we
9 just really need a better matrix of who we're talking about and what their options are with employer
10 coverage.
11 COMMISSIONER RILEY: I'd frame another question. Isn't it possible under the Affordable Care
12 Act for private donations to help pay for premiums? I'm thinking of those initial care plans for kids way
13 back when. Isn't that an allowable expenditure under the ACA?
14 CHAIR ROWLAND: I don't know.
15 COMMISSIONER RILEY: Perhaps that is a question for further study.
16 MS. DAHER: Yeah, we'll get back to you.
17 COMMISSIONER RILEY: Okay, thanks. Because that may be another model that could at least
18 short term be of assistance.
19 CHAIR ROWLAND: All right, well, thank you both very much. Now we'll move onto yet another
20 aspect of the ACA, the maternity coverage issues. Thank you. And Amy Bernstein will now join us at the
21 table.
22 * MS. BERNSTEIN: Thank you. So in addition to all of the issues that you've already heard
23 about, there are two additional issues that complicate eligibility and coverage for pregnant women and the
24 interaction with the exchange. First of all because pregnancy is a temporary state and will end at some
25 point, coverage that's limited to pregnancy in the postpartum period creates transitional issues for enrollees

1 when the pregnancy ends, or two months after. Either between different insurance plans, or between
2 coverage and uninsurance, and all of the discontinuities of care that are associated with these transitions.
3 Separate unlike a lot of other eligibility pathways, there are many different pregnancy pathways. And
4 although states are required to cover pregnant women below 133 percent of poverty level, they're not
5 required to provide full coverage through mandatory or optional poverty related pregnancy pathways.
6 Therefore, women who are eligible, there are some state that provide only pregnancy related services. And
7 women in those states may receive less generous benefits than other people in their income group. So just
8 to add a little mix to what we've already talked about.
9 So to review the eligibility rules for pregnant women under the ACA. For women below 138
10 percent of the federal poverty level, when they are applying for coverage if they check the pregnancy box
11 they must be put into their Medicaid pregnancy program. They are not eligible for the new adult group, for
12 the alternative benefit package. So keep that in the back of your mind. Once they are in the pregnancy
13 pathway states are not required to track the pregnancy, or they're not required to track pregnancy of women
14 in the new adult group or other eligibility groups. So if a women goes into the new adult group becomes
15 pregnant, states are not required to track them and then immediately put them back into a pregnancy related
16 group.
17 However, the women can raise their hand, as was mentioned, if they're enrolled in the new adult
18 group if they become pregnant, and they can request to be moved into a pregnancy program. Where they
19 may receive the enhanced pregnancy services, or they can stay in the new adult group. So I've just gone in,
20 I'm in the pregnancy group, and then when I'm done 60 days after I am not pregnant anymore, postpartum,
21 then I can go into the new adult group, or if I'm between 100 percent and 138 percent of the federal
22 poverty level I can receive health exchange subsidies. And I'll talk about that a little bit more in a minute.
23 So just I'm sure that's very clear to everyone. And I'll take questions later.
24 So now for the women who are above 138 percent, all right. Pregnancy coverage, pregnancy related
25 coverage is not considered minimum essential coverage. So if you go in, if you are in a pregnancy related

1 group or eligible for a pregnancy related group, you will be eligible for both Medicaid coverage and
2 exchange coverage, because you are entering through a pregnancy pathway. So all states, almost all states, I
3 think all but three states, will have women who are eligible for both exchange coverage and Medicaid
4 coverage, with Medicaid as the secondary payer. If a woman purchases exchange coverage and then
5 becomes pregnant on the other hand, she's supposed to raise her hand. Unlike the women below 138
6 percent of poverty, and then enroll in Medicaid. But there's no penalties if she doesn't do that. So she
7 doesn't have to raise her hand if she's in exchange coverage when she becomes pregnant, but she's
8 supposed to. In which case the state is then supposed to put her into the Medicaid pregnancy program.
9 After 60 days postpartum, then if she's in the Medicaid program she needs to find some other
10 program to go into. And if she's between 100 and 138 percent, or actually if she's above 100 percent she
11 can then enroll in exchange coverage. This is a little different than what's in your paper. Between the time
12 that we wrote the paper and now there have been some interpretations of what pregnancy related coverage
13 is. And what the IRS regulation that defined minimal essential coverage was.
14 So the IRS interpretation and CMS clarification of that interpretation clarifies that women who
15 receive their Medicaid coverage because their pregnant, whether they're getting the full Medicaid package or
16 pregnancy related services, that that is not minimum essential coverage. And the rationale is that because
17 women who enter through either mandatory or an option pregnancy pathway are not required by statute to
18 have the full Medicaid package. That it's not full coverage, even if the state decides to give them full
19 coverage. This kind of complicates what's in the paper. But basically it means that almost all women who
20 are eligible for Medicaid because they're pregnant it's not considered minimum essential coverage, and
21 they're eligible to purchase exchange coverage as well. So issues.
22 VICE CHAIR SUNDWALL: Before you leave that slide, could you go back to that. Just explain
23 the third bullet again to me. If a woman purchases exchange coverage and then becomes pregnant she's
24 supposed to self-identify and get on Medicaid?
25 MS. BERNSTEIN: Yes.

1 VICE CHAIR SUNDWALL: Even if she has insurance?

2 MS. BERNSTEIN: If she has exchange coverage above 138 percent of poverty, if you are eligible
3 for Medicaid that is supposed to trump exchange coverage. So, yes, if she is in the exchange, not ESI, but in
4 the exchange and she becomes pregnant, she is supposed to raise her hand and tell the state she is pregnant,
5 and they are supposed to put her into a Medicaid pathway if she is eligible for it in that state.

6 VICE CHAIR SUNDWALL: That's because the exchange coverage would not include pregnancy
7 care?

8 MS. BERNSTEIN: Oh, no, exchange coverage includes pregnancy care, all pregnancy care.

9 COMMISSIONER HENNING: (Inaudible)

10 VICE CHAIR SUNDWALL: Right.

11 CHAIR ROWLAND: Sharon, a mic.

12 MS. BERNSTEIN: In many states pregnancy related coverage goes up to 185 or 200 percent. If
13 you're in a state where you have a Medicaid pathway that covers pregnancy above 138 percent of poverty,
14 then you're supposed to be in that when you're pregnant, not in the exchange.

15 VICE CHAIR SUNDWALL: Why is that? Why supposed to be? Why would they supposed to be
16 in Medicaid instead? Is that the way the law is written that you're supposed to go into Medicaid not in the
17 exchange?

18 MS. BERNSTEIN: Yes, if you're eligible for Medicaid that trumps exchange coverage.

19 COMMISSIONER COHEN: But also you talked about Medicaid pregnancy program. And I do
20 feel like one thing, in the bigger picture, I was kind of interested in getting a little bit more clinical
21 information. But are Medicaid program, pregnancy programs sort of typically or some of them sort of
22 highly organized programs with wraparound and something that sort of clinically is advantageous, or is this
23 just simply a question of who pays?

24 MS. BERNSTEIN: Typically, and I think a lot of the programs are described in the June report
25 from 2012, I think almost all states have enhanced pregnancy benefits. Which include things like nutritional

1 counseling, and targeted case management, and programs to reduce unnecessary early deliveries.

2 COMMISSIONER COHEN: OH, they're sort of organized. They're not just available, they tend

3 to be somewhat more organized or no?

4 MS. BERNSTEIN: No. I mean in almost all states they're pretty organized. Because as we know

5 they cover a great many births, 48 percent.

6 COMMISSIONER CHECKETT: Yeah, and I would just say and to clarify and agree with what

7 she's saying, but even the states that are a fee for service, or PCCM programs there has really been a lot of

8 work around care management programs for pregnant women.

9 COMMISSIONER COHEN: Sorry if I'm jumping in, but I do think like a real enhancement to this

10 analyses would be sort of an understanding of whether those programs add clinical value. Whether there's

11 differences in outcomes for like comparative low income populations, or something like that. Because I do

12 think that's relevant. It's not just a question of dollars, but are there programs that are more advantageous

13 for pregnant women and have better outcomes that already exist. Otherwise we can make a

14 recommendation around exchange coverage or something without really knowing how it affects actually sort

15 of clinical care.

16 CHAIR ROWLAND: Well, also remember, one of the big changes of the plans being now

17 marketed through the exchanges to add in maternity benefits. So it isn't like this market has had a great deal

18 of experience with maternity benefits, which may be one of the reasons for shifting this transition more

19 slowly.

20 MS. BERNSTEIN: Yes. But I think the Medicaid programs would say that they add clinical

21 benefit. I mean they have said that to us.

22 COMMISSIONER RILEY: Amy, could we just talk for a minute. So many states go to 185. What

23 happens with maintenance after January 1st?

24 MS. BERNSTEIN: It's in table one in your materials. Both the 2013 and 2014 levels, and then the

25 maintenance of effort level is I think the second to the last column in the paper, not the slides. And, I'm

1 sorry, I have it here.

2 COMMISSIONER RILEY: But there's no requirement --

3 MS. BERNSTEIN: There are requirements. You can't roll back below your 1989 AFTC level. So
4 in all but 16, I think it only affects 16 states. Most of them were already at 133 percent then. All right,
5 issues.

6 So the first issue is churn that we've heard about for the last two days. And because of the issue of
7 the ending of the pregnancy at some point there will be even more churning for pregnant women than there
8 will for other women. And it will be between various pathways. The new adult group, exchange and
9 Medicaid and uninsurance. Another issue that was indirectly raised is that in Medicaid there's very little or
10 no cost sharing. If they're in the exchange there will be more cost sharing. Prenatal care is covered with no
11 cost sharing, and may of the preventative benefits that were mandated by HRSA in the regulations, spelled
12 out in the regulations there's no cost sharing, such as smoking cessation, counseling and things like that.
13 But the delivery and any complications are subject to the cost sharing requirements in the exchanges. So
14 there will be by definition more cost sharing in exchange coverage than in Medicaid or CHIP.

15 So the benefits that were mentioned, states do offer enhanced benefits for pregnancy through
16 Medicaid. On the other hand there are the seven or so states that only offer pregnancy related services. So
17 there are scenarios in your paper that sort of talk about that. But there are differences. So there are
18 differences in sort of the scope of benefits and in the actual benefits that are required. And again, as I Just
19 mentioned, exchange plans are required to provide many of these preventive services with no cost sharing.
20 But what exactly defines prenatal care or other maternity care, which is the essential health benefit, is plans
21 do have discretion in what they put into that package. So the regulation says that an essential health benefit
22 is maternity care, but it's not defined what maternity care is. Therefore, women in the new adult group
23 would receive full Medicaid benefits. But if they're in a state that has only pregnancy related service
24 benefits, they will not receive full Medicaid benefits.

25 So things to consider. The first thing that you might want to discuss is to eliminate the pregnancy

1 related service coverage only. Because, and the rationale would be that there are seven states that currently
2 provide Medicaid coverage for pregnancy related services only to specific groups of pregnant women who
3 don't qualify for Medicaid through some other pathway. And this is the majority of pregnant women in the
4 Medicaid program. We do not know, and we have put a lot of effort into trying to find out exactly what
5 pregnancy related service packages are. I mean it would be a really good question and I would expect
6 somebody to ask me that. And I'll just tell you right now we don't know.
7 The ACOG in California, other organizations that we've talked to they can't find anything in writing
8 that defines what a pregnancy related service is. It's sort of a case by case definition of if your provider says
9 it's pregnancy related then it may be covered. If anyone has any information on that I would love to hear it,
10 or find it, or be referred to it. And if there is an option that if the pregnancy related service package is
11 converted to a full benefit package, that it should constitute at least minimum essential covered for what's
12 covered in the exchanges. So that's one thing to consider.
13 The second thing would be to allow pregnant women to qualify for the new adult group, as sort of
14 spelled out in the example. If you had a husband and a wife and the husband went into the new adult group
15 he would qualify for, in expansion state obviously, he would qualify for the full Medicaid package. But if
16 they were in a state that provided only pregnancy related services, the wife would not qualify for the full
17 Medicaid, solely because she was pregnant. And once she stopped being pregnant she could then apply for
18 the full benefit package in the new group. So something to consider.
19 In your paper, again, we had an option C. Which was to allow Medicaid/CHIP coverage to wrap
20 around exchange coverage, primary to receive the enhanced pregnancy services that Medicaid would require.
21 Given the recent interpretation of the IRS ruling this isn't necessary anymore, because by definition women
22 are allowed pregnancy related coverage through a mandatory or option pregnancy pathway isn't minimum
23 essential coverage, and they can apply for exchange coverage anyhow and the state would have to
24 wraparound anyhow. And almost all states will now have to basically figure out how to do this. So with
25 that I will stop, and I look forward to your discussion.

1 EXECUTIVE DIRECTOR SCHWARTZ: Can you put it back to A, because I want to make a
2 clarifying point for commissioners. This option really goes to two things at the same time. One is it
3 addresses the issue in the seven states to the extent that they're actually is an inequity for coverage of
4 pregnant women in those states with pregnant women, and other states in terms of the range of services to
5 which they're entitled. So that's one of things it does. The other thing is, again, going back to the IRS
6 interpretation of a minimum essential coverage, to underline what Amy said. The fact that states have the
7 ability to limit to pregnancy related services is the reason why it would be not considered minimum essential
8 coverage. So if you say pregnant women get the full Medicaid benefit package, then that address that
9 concern on it being minimum essential coverage. So it's two things really at the same time. Once is the
10 acuity across states, and the other is the issue of whether pregnancy coverage under Medicaid is considered
11 minimum essential coverage.
12 CHAIRMAN SMITH: This might have nothing to do with it. But am I correct in that when you
13 pay a premium, even if it's subsidized, part of the package that you're paying for on the exchange is
14 maternity care?
15 MS. BERNSTEIN: Yes.
16 CHAIRMAN SMITH: And so they're paying the premium for maternity care, but then if they get
17 pregnant and they're in that income group -- that makes --
18 MS. BERNSTEIN: Yes. CMS is assuming that if you have both exchange coverage and Medicaid
19 coverage, the exchange coverage would be the primary payer. Medicaid is the secondary payer and would
20 wrap around with any services that the exchange coverage doesn't pay for. Which they predict would not be
21 very many services.
22 EXECUTIVE DIRECTOR SCHWARTZ: And cost-sharing though?
23 MS. BERNSTEIN: And cost-sharing for what the Exchange would require, yes.
24 CHAIRMAN SMITH: Can you clarify then? Can -- I thought you said that they have to go to
25 Medicaid if they're in that --

1 MS. BERNSTEIN: If they're already in it Exchange coverage --

2 CHAIRMAN SMITH: -- in that Exchange coverage. Right.

3 MS. BERNSTEIN: -- and they raised their hand --

4 CHAIRMAN SMITH: Right.

5 MS. BERNSTEIN: -- then they would have to go to Medicaid.

6 CHAIRMAN SMITH: Well, if they went to an OB, that would sort of signal, would it not, what --

7 MS. BERNSTEIN: If the OB somehow reported them.

8 CHAIRMAN SMITH: Well, but the payer would have to pay it.

9 CHAIR ROWLAND: No. The -- who would the OB bill? The OB would bill --

10 MS. BERNSTEIN: the Exchange.

11 CHAIR ROWLAND: -- the Exchange.

12 MS. BERNSTEIN: Yeah, and the OB would bill the Exchange anyhow because they would still be

13 in. It's very confusing. And I think they haven't actually worked out all of these details yet.

14 CHAIR ROWLAND: Donna, then Denise, then Judy.

15 COMMISSIONER CHECKETT: Amy, in the seven states that have pregnancy-related coverage,

16 how much success has anyone had in having them tell us what they do and don't pay for?

17 MS. BERNSTEIN: I've had very little.

18 COMMISSIONER CHECKETT: And you've asked that question?

19 MS. BERNSTEIN: Yes, I've had many conversations.

20 COMMISSIONER CHECKETT: Yeah.

21 MS. BERNSTEIN: It's just very hard to clarify because a lot of it is very provider-specific.

22 COMMISSIONER CHECKETT: And, you know, the -- of course the real question would be -- or

23 the real answer would be if someone literally pulled the edits in the system to see what was denying for that

24 eligibility category and what wasn't. That would actually give you your answer. Now, the states would not

25 obviously want to do that.

1 But I think as we look at the policy recommendations, you know, part of me says, I just want to get
2 to the seven and see -- you know, just explore that more -- I don't know -- in more depth of understanding
3 because it may actually turn out not to really be a problem, you know. Total hypothesize, but I'll bet that
4 there are very few edits in the system in at least half of those seven states that are actually denying care.
5 Sometimes you have a political solution and then you have a reality implementation. But we don't
6 know that. So that would be of great interest to me. So thank you. Yeah.
7 MS. BERNSTEIN: The advocacy groups that we've talked to seem to think that it's a problem, at
8 least in California. They have published an alert -- it was a joint alert of various advocacy organizations that
9 say that there are -- they have documented women who have not received services for brain tumors and
10 broken arms and things like that. Again, it's advocacy, so, you know, I don't know.
11 COMMISSIONER CHECKETT: Right. Yeah, no. I understand. But I mean, this is clearly so
12 problematic and distressing in terms of pregnant women and just, you know, how critically important their
13 health is but I think we really need to dig in on those seven states before we take, like, you know, a hammer
14 approach to what, you know, maybe not necessarily be needed. So good luck, you're thinking. Okay.
15 MS. BERNSTEIN: I've tried. I --
16 COMMISSIONER CHECKETT: Okay. All right. Well --
17 MS. BERNSTEIN: You know, I've -- COMMISSIONER CHECKETT: -- my comments then are
18 directed to Anne and Diane on that. But thank you, Amy, for really good work on a very complicated issue.
19 EXECUTIVE DIRECTOR SCHWARTZ: Donna, we have tried to go from both ends.
20
21 EXECUTIVE DIRECTOR SCHWARTZ: We have tried to go from both ends. We've tried to go
22 through the Medicaid Directors and then we've tried to go through the advocates as well and we have not
23 had much luck. And the one thing I want to point out is that if we find that coverage really is very different
24 in those seven States, then there is an equity problem that you might want to address.
25 UNIDENTIFIED SPEAKER: Right.
26 EXECUTIVE DIRECTOR SCHWARTZ: If we find, in fact, there is no difference that, in fact,

1 this is just sort of in name only and they are treated like other folks and given the full Medicaid benefit
2 package, the fact that the -- that they -- that that option exists for them, even if they're not doing it, is the
3 thing that triggered this notion that it's not considered minimum essential.
4 COMMISSIONER CHECKETT: Right, yeah, yeah.
5 EXECUTIVE DIRECTOR SCHWARTZ: [Inaudible].
6 COMMISSIONER CHECKETT: Yeah, I appreciate your perspective on it, Anne. Thank you.
7 UNIDENTIFIED SPEAKER: Denise, Judy, Mark, David.
8 COMMISSIONER HENNING: So for this group of women that are in the income range where
9 they have to raise their hand and move from exchange coverage to Medicaid, Medicaid -- I mean, the
10 exchange coverage still is in effect as far as it -- the Medicaid just wraps around the exchange coverage; is
11 that what we're talking about or --
12 COMMISSIONER BERSTEIN: That seems to be what the recent interpretation is.
13 COMMISSIONER HENNING: The latest greatest?
14 COMMISSIONER BERSTEIN: Yeah.
15 COMMISSIONER HENNING: Okay. So that the thing that really concerned me about the
16 exchange coverage is that when you get to the delivery end, when you actually go into the hospital to deliver
17 your baby, and you have a 20 percent co-pay of that $10,000 hospital bill for somebody that's, you know, in
18 relatively low income, certainly not the Bill Gates of the world, that could be a really big bill for a new family
19 to have to pay. So if Medicaid could, in fact, wrap around their exchange coverage, that would be a real
20 benefit to that family.
21 COMMISSIONER MOORE: I think actually, with this group, which is very low
22 income regardless of which percentages you're dealing with in most cases, I'm ready for the hammer. I'm
23 actually ready to say as a matter of policy for this group of women, the Commission wants to seek simplicity
24 and, as a practical matter, pay for and wrap Medicaid into coverage for these people to the greatest extent
25 we possibly can.

1 And there's another reason and that is because the newborn will get picked up
2 immediately if the mom is covered by Medicaid or if, at least, there's a Medicaid wraparound, so that's sort
3 of just a statement of sort of overreaching policy that I would feel comfortable with. And I don't know
4 where the pieces fall out because it's complicated and I don't mean to be denying that, but I think that
5 would be the general direction I'd favor going in.
6 COMMISSIONER HENNING: I paid her to do that.
7 UNIDENTIFIED SPEAKER: What?
8 [Off microphone conversation.]
9 [Laughter.]
10 COMMISSIONER MOORE: Okay. Then I have Mark, David and Andy.
11 COMMISSIONER HOYT: One of the things Mercer saw and we were working on different ways
12 to reimburse for maternity -- this is kind of back under the "old days" where the eligibility lines for
13 pregnancy I would say go up to 185 and other ones were much lower for TANF or AFDC. You'd see a lot
14 of women come in and present for dental services when they were pregnant. If the State -- and I know a lot
15 of States have changed this, but in the seven-state query you make, you might asked whether they still cover
16 adult dental and then you'd debate some. Is that pregnancy related or what's the effect of that? That was --
17 those --
18 [Off microphone conversation.]
19 COMMISSIONER HOYT: Yeah.
20 CHAIR ROWLAND: Actually, dental is one of the things that is almost always considered
21 pregnancy related because --
22 COMMISSIONER HOYT: Okay.
23 CHAIR ROWLAND: -- there's clinical evidence that they're correlated.
24 COMMISSIONER HOYT: Because I was going to say Mercer was asked -- several States I know
25 that moved from pregnancy-only to full coverage, you know, adjust the rates for that. And we can never

1 find anything either and, you know, typical actuaries may be -- we would just talk to people and then in the
2 end, we just negotiated to like 1 or 2 percent or we'll try it and see what the experience is, and I don't think
3 it was ever debated beyond that. You know, you'd adjust the rates or the supplemental payment by some
4 small amount and that was it. It's just almost immaterial.

5 CHAIR ROWLAND: Okay. David?

6 VICE CHAIR SUNDWALL: Yeah, this issue is interesting just because, as you know, my interest
7 in public health. There's probably one of the most popular public health indicators is pregnancy outcome, a
8 premature birth, infant mortality, so I think, as a matter of policy, we should promote this coverage. How
9 we do it -- I mean, it seems to me arguing who's paying again, exchange or the Medicaid, but it ought to be,
10 like even Judy said, a statement of policy that there be coverage for pregnant women.

11 Do you have any health data or outcomes data for these seven States that are in this situation? Are
12 they less healthy? Are there infant mortality or premature births or problems higher than other States?

13 COMMISSIONER BERSTEIN: Not for Medicaid births in particular. But again, I mean, these
14 States are covering anything that's related to the pregnancy, so they could have very good pregnancy
15 programs, I mean, that focus specifically on the pregnancy and the birth. It's the non-pregnancy services
16 that aren't being paid for. So I'm not --

17 VICE CHAIR SUNDWALL: But the birth outcomes were good.

18 COMMISSIONER BERSTEIN: Yeah. I mean, but the birth outcomes would be more related to
19 what they're receiving as pregnancy related services, right? I mean, if you're looking at infant mortality or
20 early deliveries or very low birth weight, that would be covered because they're covering the pregnancy
21 related services, so they might have, you know, fabulous pregnancy coverage, it's the other coverage that
22 they're not getting because they can't be in the new adult group.

23 VICE CHAIR SUNDWALL: Do you know how many States have presumptive eligibility for
24 pregnancy?

25 COMMISSIONER BERSTEIN: Many. It's in the chapter of the June report. I don't know

1 offhand, I'm sorry.

2 CHAIR ROWLAND: The seven States that offer this most of them -- three of them are not going

3 forward with the expansion and the other ones are?

4 COMMISSIONER BERSTEIN: Three are. Three are ones on the fence.

5 CHAIR ROWLAND: So in analyzing this, do we not need to look at the implications depending on

6 whether the State is going forward because, obviously, if the State is going forward and the Medicaid

7 eligibility levels for full Medicaid are being raised to 139 or maybe even higher, it's a different situation than

8 if the eligibility levels are down at 18 or 19 percent of the poverty level. I think you really need to

9 disaggregate whether the policy implications here are the same depending on what the situation of the

10 State's current eligibility policy is.

11 COMMISSIONER BERSTEIN: It's the -- I'm not sure I understand. I mean, the issue for this

12 recommendation is that women are receiving fewer services than other people who are exactly like them

13 except they're not pregnant.

14 EXECUTIVE DIRECTOR SCHWARTZ: Except if they haven't -- it's -- they're in a State that

15 hasn't expanded --

16 UNIDENTIFIED SPEAKER: Expanded.

17 EXECUTIVE DIRECTOR SCHWARTZ: -- then that -- for those two States, if they haven't

18 expanded, that's -- you can't say that. You can't say that.

19 COMMISSIONER BERSTEIN: Then the recommendation wouldn't apply.

20 EXECUTIVE DIRECTOR SCHWARTZ: Right.

21 CHAIR ROWLAND: Yeah. Well, you can't put someone in the new adult group if there's no new

22 adult group.

23 EXECUTIVE DIRECTOR SCHWARTZ: Adult group.

24 COMMISSIONER BERSTEIN: Right, which is --

25 EXECUTIVE DIRECTOR SCHWARTZ: Right.

1 COMMISSIONER BERSTEIN: -- that's Recommendation B.

2 EXECUTIVE DIRECTOR SCHWARTZ: Right, right, right.

3 COMMISSIONER BERSTEIN: So, I mean, that's why there are two different recommendations.
4 One of them applies to all women in the seven States. The other one only applies to the expansion States,
5 so they're -- I mean, it takes both of those contingencies.

6 CHAIR ROWLAND: Okay. Andy and then Steven.

7 COMMISSIONER COHEN: So again, just to sort of summarize a little bit. And
8 the last point made me think about this a little bit differently. There's two issues and it depends on what the
9 State's situation is. One is whether or not there's an inequity because a pregnant woman in a State that only
10 provides pregnancy related services, in theory, is getting less services than a similarly situated woman who is
11 not pregnant, and that's an equity concern in expansion States.

12 And then, in addition, there's a concern in non-expansion States that we don't really know what
13 "pregnancy related services" really means. We sort of have evidence and maybe like anecdotal in both
14 directions that it really means everything and it really doesn't, and so there's a question around that. And I
15 sort of come back to that -- for that -- in that circumstance in order to make the case that pregnancy

16 -- you know, if we don't have data on what "pregnancy related services" really means in each State,
17 we're going to have to make some sort of assumption that it is, in fact, a limitation, right? I mean, because
18 otherwise, you know, like without the data, we can't assume anything other than it is, in fact, a limitation.

19 And then I would like to see what those limitations kind of might mean for outcomes and other
20 things. And again, even if it's sort of -- we almost have to like present a hypothetical. I kind of -- I assume
21 that pregnancy-only services -- I sort of can't imagine that somebody would come up with that today, maybe
22 I'm wrong, that it may be a little bit of like a historical throwback in a time when medicine was practiced a
23 little bit differently or, you know, I don't know. But those are the kinds of questions that I would like to feel
24 a little bit sort of more comfortable with before addressing that part of the issue, like is pregnancy related
25 services something that is inherently inadequate? I suspect, frankly, that it is.

1 And again, if we don't have the data and a State today has no edits in their system, but they're
2 allowed to have them, then tomorrow they could have the edits in their system. So again, I sort of come
3 back to -- for that part of the problem, I'm interested in a little bit more clinical information about how
4 things are practiced, what situations come up, what could be limited.
5 And then I think the other piece that is helpful, in terms of thinking whether our -- a
6 recommendation might go in the direction of encouraging more exchange coverage versus not, is
7 understanding a little bit more, which may -- I may need to review the old chapter, but a little bit more
8 about what Medicaid pregnancy services offer as opposed to what exchange coverage offers. And again, it's
9 not just a question of benefits sometimes, it is the coordination and the things that go with it.
10 CHAIR ROWLAND: Steve and then Robin.
11 COMMISSIONER WALDREN: So a couple of things. So first, I don't think we'll -- we would
12 ever be -- won't ever, but for the data that's out there now, we're not going to be able to tell what's
13 pregnancy and not pregnancy related from a clinical perspective because --
14 CHAIR ROWLAND: Right.
15 COMMISSIONER WALDREN: -- because every time you see a pregnant woman, no matter if it's
16 pregnancy related or not, I'm going to put "pregnancy" down on -- as an ICD-9 and an ICD-10 code for the
17 service because that deals --
18 COMMISSIONER COHEN: You are, but the question is: is that common practice across every
19 single --
20 COMMISSIONER WALDREN: I'm getting there.
21 COMMISSIONER COHEN: -- provider in the -- yeah.
22 CHAIR ROWLAND: He's getting there, hold on.
23 COMMISSIONER WALDREN: Because I think -- I would assume that it is because the fact that
24 somebody's pregnant and I'm going to take that into account and pretty much anything I do, that adds to
25 the medical complexity of that particular encounter or service and, therefore, leads to a higher payment. So

1 I would -- it would hard -- it would be hard for me to say that somebody has four -- so right now, an ICD-9
2 and let's say we're back into 4010 in regard to the transaction claim because we're looking at data that's
3 before a couple years ago, if there are only four or five ICD-9 codes I'm going to put in there, it would have
4 to be a pretty complicated issue with a patient that there are four codes that I would put before -- you know,
5 before I would put -- finally put the code for a pregnancy to show the complexity of that particular patient.
6 So that's one issue. I don't think we'll ever get to that episode of care type of data because we just don't
7 have it. We'd have to have a new system to collect that type of data.
8 The other thing I'm struggling with is this notion of what's pregnancy related or not pregnancy
9 related in coverage. I think if we said that Medicaid was a wraparound and it gets to that issue of
10 somebody's already paying for maternity care, either it'd be Federal subsidy or the patient doing that based
11 on what type of subsidy they get, it does kind of push the issue of what's pregnancy related or not to the
12 exchange and Medicaid and they've got to figure that out, but it's at least covered, supposedly.
13 But if a patient has a broken arm and there's two patients, they're both similarly situated cost-wise,
14 one -- there's three of them. So one's pregnant, one's never been pregnant, one's 92 days postpartum, you
15 know, just because they're pregnant I don't think they should be covered for that when the other two
16 women are not and vice versa. So if they get pulled out of exchange and put into Medicaid and it's one of
17 these things that these are not covered but in exchange they would have been covered, I think that's an issue
18 we should take up. If it's an issue where it's, you know, additional services because they're pregnant, you
19 know, that puts an inequity, I think, in those that women are not pregnant if it's not pregnancy related, so I
20 think that's another issue to throw into the mix.
21 COMMISSIONER SMITH: Are we putting the onus on the patient, the beneficiary, to understand
22 this and to --
23 [Off microphone conversation.]
24 COMMISSIONER SMITH: -- figure it out and know when to do what? And if they have to be the
25 one to raise their hand or -- it's not going to happen.

1 CHAIR ROWLAND: I think you're recommending that we look at our simplification and
2 streamlining and our patient perspective of what's there, and that really does get to whether they have less
3 benefits because they end up in the exchange in terms of whether it's a case coordinator or the ability to be
4 enrolled in a plan that pays for prenatal care and -- you know, there's a lot of RAP plans that are out there,
5 too, so we really need a little more understanding of what the risk is of saying, "If you're in the exchange,
6 you get your benefits through the exchange. If you're in Medicaid, you get full Medicaid benefits," and what
7 happens in these seven States.
8 Denise.
9 COMMISSIONER HENNING: Well, going back to Steve's example, if I have a non-pregnant
10 woman and she has insurance coverage through the exchange, then she is going to get her broken arm taken
11 care of. My pregnant lady that gets forced into this pregnancy-only Medicaid is not going to get her broken
12 arm taken care of and she has a higher risk of throwing a blood clot and so does my postpartum lady, so
13 that's, you know, kind of one situation to think about.
14 But the other thing I'm wondering: is there a real benefit to this? Is -- are States using this to cover
15 people in Medicaid through a waiver or that otherwise they would not be able to pay for, i.e., undocumented
16 women's pregnancy-only coverage? Because that's the only reason I can think of that you might want to
17 keep this. Otherwise, I'm with Judy, get rid of it.
18 COMMISSIONER BERSTEIN: Undocumented women are not eligible for either the mandatory
19 or the optional pregnancy pathway. They have to go under the unborn child option State funding that's not
20 Medicaid.
21 COMMISSIONER MARTINEZ ROGERS: But, Denise, I think that the issue isn't whether or not
22 the woman's broken arm would be taken care of, it's who's going to pay for that broken arm or where's the
23 money coming from? I mean, because I can't imagine any care provider ignoring -- saying, "I'm only taking
24 care of your pregnancy," and ignoring the broken arm. I just can't, in my mind.
25 COMMISSIONER HENNING: I understand.

1 CHAIR ROWLAND: Okay. I think that we've clearly asked for a lot more information about a
2 very confusing situation.
3 [Off microphone conversation.]
4 CHAIR ROWLAND: So we will hopefully get more information back at our next meeting and
5 Amy will try and figure out what that is that we want, but I'm sure we can work it out.
6 But really to understand, I think much more about the Medicaid pregnancy-only option in those
7 seven States is clearly one piece we need.
8 And I'm going to call Moira up to take us into program integrity, which we always like to deal with.
9 [Off microphone conversation.]
10 * MS. FORBES: All right. Thank you.
11 Good morning. So as we've been discussing all morning, the ACA mandates many changes to
12 Medicaid and CHIP eligibility policies to reduce the complexity and the effort associated with the eligibility
13 process, and these changes are being driven by many factors: there's the increased pressure the Medicaid
14 expansion and enrollment outreach efforts are putting on States; there's the desire to align Medicaid with
15 other subsidy programs including the low income -- or the tax credits; and there's the availability of new
16 support such as the information hub that will support Medicaid and the exchanges.
17 So, many of these changes are designed to reduce complexity and effort in order to simplify and
18 streamline the enrollment process from the State perspective, to help increase the percentage of eligible
19 persons who are able to successfully enroll, and to reduce errors that result from the challenge of
20 consistently applying complex eligibility information.
21 So two of these significant changes, from a program integrities perspective, are the move to the use
22 of modified adjusted gross income instead of all these complex income-counting and disregard rules that
23 previously existed and the replacement of in-person and documentation-heavy processes with online
24 applications and automated third-party data checks, so that's what I'll be talking a lot about this morning.
25 So over the next few slides, I just want to illustrate how these new ACA changes are different from

1 past efforts and how they might affect different types of eligibility errors. And the screen will be a little
2 different from your slides so you might want to look at the screen.
3 Okay. And so an eligibility system that is working properly will accept applicants and determine
4 who -- and people come in. They're either eligible or they're not eligible. And then we have a process to
5 determine whether they're eligible and we'll give them eligibility or determine them to be ineligible.
6 No system is perfect and there's always going to be a certain, you know, amount of errors, so for
7 eligibility program integrity, we can sort of simplify these into two categories of errors: false negatives -- oh,
8 I'm sorry. People are eligible or not eligible. That -- these are the outcomes we want. False negatives are
9 when someone is eligible but are not given eligibility. They don't receive the benefits that they are entitled
10 to, which can cause them harm. False positives result when the system determines someone eligible who
11 does not actually qualify. This can lead to inappropriate spending and a lack of confidence in the program.
12 So the eligibility rules and processes, which are illustrated by this red line here, can affect the number
13 and type of errors that may occur. The next couple of slides will show that a little more clearly.
14 So traditionally, strategies to minimize false positives, persons who get Medicaid eligibility even
15 though they don't qualify, have relied on applicants to prove their eligibility by showing up for in-person
16 interviews, providing a lot of documentation of their income and assets and limiting the people who can
17 make eligibility determinations to certain State workers. So while these strategies can improve the accuracy
18 of "Yes" determinations, they can also lead to greater incidents of false negatives, people who should be
19 eligible but are not found eligible because they will not or cannot provide the required documentation
20 within the allowable time frames, they miss appointments for in-person interviews, or they cannot easily
21 access application sites. We have more people who should be getting benefits who aren't when you have
22 tight documentation rules.
23 When access is a concern, States can improve coverage without expanding eligibility simply by
24 increasing the proportion of eligible persons who are able to successfully enroll, or reducing false negatives.
25 And since the late 1990s, Federal guidance has promoted more flexible application and documentation

1 standards to help reduce the number of false negatives and increase enrollment of the truly eligible. But a
2 consequence of this is an increased risk for false positives. If less documentation is required, it can be more
3 difficult for States to determine when an applicant has reported inaccurate information, which can lead to
4 eligibility errors and improper payments.
5 So some of the ACA-driven eligibility changes I discussed on the first slide, particularly the move to
6 MAGI and away from complex income-counting rules, and the replacement of documentation-heavy
7 processes with automated third-party data checks, will have the effect of changing, you know, where we
8 draw this line. It's moving a lot of the obligation for program integrity away from individual applicants to
9 the State by requiring States to rely on reliable third-party documentation. The ACA gives States broader
10 access to reliable third-party sources of data to verify eligibility, the hub. This should help reduce false
11 positives.
12 It also requires States to use these third-party sources whenever possible instead of required
13 applicants to document their eligibility. This should help reduce false negatives.
14 And when these eligibility changes are fully put into place, we should have a lot more accuracy in
15 terms of both who we determine eligible and who we determine ineligible. Automation of these processes,
16 in addition to improving accuracy, should also increase speed and reduce costs.
17 But the question is: is this going to work and how are we going to know, which is why I haven't
18 drawn a line here. I've left it a little fuzzy. So on the first question: is this going to work? We want to make
19 sure that these systems are not sacrificing program integrity by creating new types of errors so we do need
20 to think about what the changes are and what kind of program integrity approaches are appropriate, so I'll
21 walk through a couple.
22 A big change is this reliance on self-reported information and what's called the "reasonable
23 compatibility standard." Medicaid going forward will largely rely on applicant's self-attestation of income
24 and other program eligibility factors, with the exception of citizenship and immigration status which would
25 still be verified. So States can only require applicants to provide documentation if self-reported information

1 is not reasonably compatible with information in Government databases. This is a big, big change and a lot
2 of States are not happy about this. They cannot ask up front for documentation from applicants. The
3 States can set the threshold for when self-reported information is considered reasonably compatible, and
4 most appear to be using a 10 percent threshold.

5 The effect on program integrity of a widespread shift away from applicant-supplied documentation
6 and reliance on third-party databases is not yet known. Some States have widely adopted ex parte
7 verification methods for self-attested information, some States have used this a lot at redetermination and it
8 appears that it did not have a big impact on program integrity, but we haven't gone to this in every State.
9 We just don't know yet.

10 Post-enrollment verification. An option for States -- and one thing that CMS is encouraging, as part
11 of supporting real-time enrollment eligibility determinations, is to allow States to choose to verify
12 application information after enrollment is improved -- approved. So the State can determine a Medicaid or
13 CHIP applicant eligible based on self-reported information, tell them, "You're eligible," then do their
14 verification as needed through matching to electronic data sources. And the goal is to not lose people as
15 you're going through that process and to get people into care, when they are motivated to -- when they're at
16 the point of showing up and seeking it.

17 Again, the effect of these changes on program integrity isn't known as this is a new provision. Some
18 States have done this and found that -- they've done audits and found that it does not appear to increase
19 errors, but again, it hasn't been done on a wide scale. This doesn't eliminate verification. It just means that
20 the State can tell a person that they're approved and then conduct the verification.

21 Another challenge is going to be coordination with exchanges. Coordination and sharing of
22 eligibility information among Medicaid, CHIP and exchanges is a new component of eligibility policy.
23 Previously, only certain State single-state agency eligibility workers, or people designated at the county level,
24 could determine someone Medicaid eligible. And now, obviously, the Federal Government can do that if
25 the State allows the Federal hub to do that, and a State hub can also be designated to do that.

1 As of October 1, 11 States were allowing the Federal marketplace to make determinations, and 25
2 more were allowing the Federal exchange to assess applicants for potential eligibility.
3 So the Federal Rules require States to have written agreements with Federal or State marketplaces if
4 they will determine Medicaid eligibility on behalf of the State. And CMS has said that the State retains
5 oversight responsibilities for all decisions, but it's not clear exactly yet if there are errors, you know, who's
6 going to be on the hook for that, which is -- since we are already doing this -- this started on October 1 --
7 there's, you know, some concern that it's not clear exactly what will happen if there are problems.
8 So ensuring the accuracy and security of information shared between the programs is important, you
9 know, but HHS has only said that it will issue future guidance.
10 And finally, there is something new: these verification plans. So States have, you know, some
11 flexibility in establishing verification procedures for various factors of eligibility, which include, you know,
12 income, residency, age, household comp. You know, they can decide if they're going to do post-eligibility
13 verification, they can decide which databases they're going to check, and then they can decide if they're
14 going to delegate things to the Federal hub.
15 CMS is now requiring every State to develop and submit a verification plan describing the policies
16 and procedures that will be followed to implement these changes, so this is new. There's a consistent set of
17 documentation that States are required to submit to the Feds. About half of the States have submitted these
18 so far and they've been reviewed and posted on the CMS website.
19 So the State's standards and processes outlined in the verification plan will serve as the basis for
20 future eligibility quality control audits. There's a lot more transparency now and having these plans is -- has
21 -- is helpful for understanding what choices they're making and providing those clear bases for the audits.
22 So in terms of these audits, while CMS has not issued detailed guidance to States on how to mitigate
23 some of these potential risks, it has developed a program to provide timely information on potential
24 problem areas, and this may be used to inform new policies, develop additional guidance, and update quality
25 control procedures.

1 So I think we've -- I think we talked about this past spring, CMS and the States. There are two
2 retrospective eligibility quality control programs: a Payment Error Rate Measurement program, and the
3 Medicaid Eligibility Quality Control program, both of which require States to sample and audit a certain
4 number of eligibility cases each year.

5 Given the widespread changes in eligibility policy and the amount of flux that there is in the system
6 right now, CMS has temporarily replaced PERM and MEQC with pilot programs, so starting with the fiscal
7 year that just began on October 1 and for the next two fiscal years, the traditional measurement is going to
8 be on hold and States will not be developing a state-wide sort of statistically-valid measure of improper
9 payments for Medicaid and CHIP.

10 What they're going to do instead is: all of the States each year are going to do a pilot, and the first
11 pilot is for the October 1 to March 31st period and States are going to be reporting in June. That's the
12 fastest I've ever heard of a State reporting the results of an audit, but it will give CMS and the rest of us, I
13 think, some pretty early insight into what kind of issues States are seeing. They'll do another pilot for the
14 second half of this fiscal year, and then they'll do them for FY 15 and 16. And so the goal is to get some
15 much-faster information on the kinds of things we are actually seeing.

16 So the reviews will assess sort of the traditional eligibility program integrity questions like: Was
17 household composition income level properly established? Was citizenship and immigration status properly
18 established? Was the decision about program eligibility correct? And was the decision about eligibility
19 group correct?

20 What the pilots are also going to look at are some other aspects that have not traditionally been
21 included in eligibility quality control review, but which should be looking more at false negatives and looking
22 at some of the new eligibility policies that are going into effect. So they'll be looking at if the Medicaid
23 decision has been finalized and denied, was the case transferred to the State or Federal exchange? States
24 have an explicit responsibility, if you apply for Medicaid and you don't get Medicaid, to transfer that
25 application and that information to the exchange so that you can be assessed for the tax credits or for

1 exchange eligibility. And so we're going -- States are now going to be required to look at are they doing that;
2 is that handoff actually working?
3 If the application was transferred from a State or Federal exchange, were appropriate steps taken to
4 ensure reuse of information, that you don't go out and ask the applicant to supply something that they
5 already gave to the exchange.
6 Were the appropriate attestations or verifications made for data collected in the application, as
7 identified in the State's verification plan? These are all new things. We're going to test them in these pilots.
8 We're going to see what kind of result -- what kind of results we get and, also I think, learn a lot about how
9 you go about measuring these things, and then CMS will be in a better position to issue some updated
10 quality control guidance.
11 So for us, like I said, we're monitoring this. I mean, I'm interested to hear if folks have any ideas
12 about specific things we should be monitoring, based on all the changes in the policy, but I think, at this
13 point, largely our job is to see -- watch how things are going, see how these interactions with the hub when
14 States start getting the Medicaid applications transferred, hopefully later this month or next month, you
15 know, see how that process goes and then, you know, report back to you later on what we're seeing. But if
16 there's specific things that you would like us to monitor, we can certainly, you know, put that on our list.
17 CHAIR ROWLAND: In terms of Medicaid eligibility, these processes apply to the changes enacted
18 for low-income families and basically through the ACA, the MAGI.
19 Are the old processes still in effect for determination of people with disabilities then for the elderly
20 or how widespread are these policies? Is PERM still there for them?
21 MS. FORBES: No. That's actually a good question. No, PERM has been suspended and CMS --
22 CHAIR ROWLAND: MAGI.
23 MS. FORBES: -- has been clear that the samples should focus on the MAGI populations for now.
24 So, yes, so they're not looking at -- whatever a State's error rate was in its last measurement has been frozen
25 essentially until after FY 16.

1 CHAIR ROWLAND: Okay. David, then Trish.

2 VICE CHAIR SUNDWALL: Well, thank you. I'm always amazed the more I learn about the ACA,
3 how unceasingly complicated it is. We'd made comments, as a commission, last year on program integrity
4 and as I recall, the gist of what we identified is that it was very, very complicated, redundant, costly, possibly
5 costing as much to implement all these programs as they were recouping dollars that were inappropriately
6 spent.

7 Do you see any evidence in this new ACA that there's -- they're trying to address that complexity? I
8 see the simplification of the eligibility enrollment as you've described it, but it seems -- it's just multiple
9 pilots.

10 Every State is demonstrating independently how they're going to implement these new
11 requirements?

12 MS. FORBES: I think that -- well, I think we've all seen that -- the challenge CMS has had and how
13 much time it takes to implement or to issue the guidance on the actual underlying policy and then to get it
14 implemented, so I think it makes sense to do the pilots, see what they're finding and how -- I think how we
15 go about measuring these things is also going to be completely different, so I think it makes sense, that it
16 gives CMS an opportunity to figure out the most efficient way to make sure that we're appropriately
17 measuring going forward. So I hope actually that this pause gets at some of the things that the Commission
18 recommended in terms of being smart about how we measure program integrity.

19 VICE CHAIR SUNDWALL: So maybe I'm having a little trouble with the word "pilot." I think
20 what they're doing is: they're giving them some time to report back on what problems they're encountering
21 in implementing the new rules or --

22 MS. FORBES: They're required --

23 VICE CHAIR SUNDWALL: -- what their experience is, but they're not really doing a
24 demonstration project. They're just trying to document -- they want to document for CMS how they're
25 going about it and what problems they're encountering along the way?

1 MS. FORBES: No, they're required to pull 200 eligibility cases that were determined eligible
2 between October and March and do an audit of those cases on all of these elements and then report to CMS
3 in June about the findings. So they are -- no, they are auditing hundreds of cases this year. All of the States
4 are being required to audit hundreds of cases across all of these dimensions and report on it very quickly.
5 That's what's different about it. Normally, only a third of the States would be doing it. They're actually --
6 VICE CHAIR SUNDWALL: Interesting.
7 MS. FORBES: -- requiring more audits this year. They're also giving States test cases and having it
8 run through some of these automated systems to see that --
9 VICE CHAIR SUNDWALL: Hmm --
10 MS. FORBES: -- make sure that all the connections are working as well.
11 VICE CHAIR SUNDWALL: Sounds like proficiency testing in labs. We give them unknowns and
12 see if --
13 MS. FORBES: Yes.
14 VICE CHAIR SUNDWALL: -- they can run the test?
15 MS. FORBES: Yes, that is what they're doing.
16 VICE CHAIR SUNDWALL: Interesting.
17 COMMISSIONER RILEY: It's actually rather encouraging when you think about how the ACA
18 has fundamentally changed what a Medicaid eligibility program does, you know. You now want people in,
19 not out, and it's simplified and streamlined. It's -- it sounds pretty encouraging and like a new day of
20 collaboration with the States.
21 But the other element of it would be: what are they doing about error rates and penalties? I mean,
22 have they also suspended -- if there's going to be this collaboration to figure out how self-attestation and so
23 forth works, there's got to be, on the other hand, some kind of flexibility on penalties until this thing all
24 plays out. So I would like to track the error rate issues and what the penalties would be as well.
25 MS. FORBES: Uh-huh (affirmatively).

1 COMMISSIONER WALDREN: So I think this construct of the false positives and false negatives
2 is a good construct for us to look at which correlates to sensitivity and specificity where sensitivity deals
3 with the notion of false negatives, and specificity the false positives.
4 One of the things in -- when you start thinking about that, it's dependent upon the population that
5 you're applying that test to, so just like in the clinical world when you're doing -- looking at strep test, there's
6 a sensitivity and specificity. But if you take patients that have a cough and those that don't, the sensitivity
7 and specificity of those two groups of that same test are significantly different. And I'm just wondering if
8 we start looking at this, are there those predictors that we could look at and say, "Well, something that had
9 very poor" -- you know, had a big false and -- false positive rate like the -- we're talking about the
10 documentation last, but if we look at the groups and said, "Well, but this particular group and -- is different
11 than this by this one characteristic," the sensitivity and specificity are significantly different where, you
12 know, we could say, "We could even have less documentation for this group because the sensitivity was so
13 different for this group versus somebody that is in a different group" so.
14 CHAIR ROWLAND: I think as a follow-up to that point, I mean, some individuals are going to
15 come in through SNAP and through other sort of fast-tracking, and is the fast-tracking working better or
16 not as well as the direct entry, you know, and to flag areas where it could be problematic as well as areas
17 where it's probably not worth doing as much tracking.
18 Judy's next.
19 COMMISSIONER MOORE: Thank you. This is actually really interesting. I -- because the
20 systems they've used so -- for so long in the past have been -- are really antiquated and we've had interesting
21 folks speak to us from the States before, I guess I think we would do well to continue to monitor this fairly
22 carefully. I suspect that the IG's Office and the GAO and a lot of other people are doing the same and I
23 hope we'll stay in touch with all of them on what their views are, and I'd love to hear from the States about
24 it.
25 I hope and I assume that there is a -- there's a national view being taken of this, that it is coordinated

1 -- I mean, I assume. I shouldn't assume. I hope that there is an integrated look at this with many States
2 with different levels of expertise and a commitment to this being -- testing the same kinds of things and I
3 think it would be very useful to follow it over at least the next six months to a year to see where they're
4 going to come out.
5 CHAIR ROWLAND: We've also never had much of a sense of how many people should have
6 gotten on but didn't and so I think having both sides of that equation are really important to monitor. It's
7 not -- you know, we always get all the attention of how many people got onto the program that shouldn't
8 have gotten on, but now we really want to look at how many people are not able to get on and should have
9 gotten on.
10 UNIDENTIFIED SPEAKER: Right.
11 CHAIR ROWLAND: And that, I think, will be a harder thing to audit, right? You'll have to look at
12 the denied applications?
13 COMMISSIONER CARTE: Well, it's part of the PERM error rate, the ones that didn't get on
14 because back in the day, when they set up PERM, the CHIP directors were insisting on that.
15 CHAIR ROWLAND: But PERM has been suspended now, right?
16 MS. FORBES: They do look at denied cases. What's interesting now and, I think, part of the
17 reason they're -- is that if you don't get on Medicaid, you're supposed to go to the exchange, so there's --
18 people have somewhere to go, and the Feds are on the hook more if they go there. So I think there is a lot
19 of interest in making sure that people are ending up in the right program.
20 COMMISSIONER CARTE: But also, Diane, I really appreciate your point about bringing up
21 SNAP. I mean, SNAP is now in use. It's almost a proxy for eligibility so to further look at how sensitive or
22 specific that is as a proxy would be -- and I would hope that CMS has that as part of the testing.
23 CHAIR ROWLAND: Thank you very much. I -- obviously, we want to continue to follow this,
24 but that was a great presentation. Thank you.
25 So now, we'll take a brief break and then return to talk about supplemental payments.

1 [Whereupon, at 11:32 a.m., the meeting was recessed, to reconvene at 11:40 a.m. this same day.]

2 CHAIR ROWLAND: If we could please reconvene.

3 If we could please reconvene. And we are going to continue or discussion of non-DSH
4 supplemental payments and how they work and what we know about them and what some of the options
5 we might want to consider for looking more deeply into this issue.

6 So Jim Teisl will lead us through this discussion.

7 **### SESSION 6: Medicaid Non-DSH Supplemental Payments**

8 * MR. TEISL: Thank you. And good morning, everyone. So the plan for this session is, first,
9 to quickly review a bit of background regarding non-DSH, or what we've referred to in the past as "UPL
10 supplement payments," and then to discuss the rationale for a number of potential policy options that the
11 Commission may wish to consider further. We'll walk through several broad options and then open it up to
12 discussion. I should mention these options are broadly stated.

13 And at the outset, I also want to emphasize that in developing the options, we tried to cover a range
14 of possibilities, everything from just simply continuing to monitor non-DSH supplemental payments all the
15 way to fundamentally rethinking the role of these things in the Medicaid program. We acknowledge there
16 may be other options that fall within that range and we very much look forward to your input on which, if
17 any, you have interest in pursuing.

18 So as you'll recall from our work in 2012 and more recently, our analysis working with data provided
19 by several States voluntarily, both supplemental payments and what I call "provider-contributed non-federal
20 financing," such as healthcare related taxes, play important roles in Medicaid payment. This appears to be
21 especially true for what are known as "institutional providers," most commonly hospitals and nursing
22 facilities.

23 So both of these things complicate our ability to analyze Medicaid payment. As you recall,
24 healthcare related taxes effectively reduce the net amount of Medicaid payment if you consider that some
25 portion of the non-federal share was contributed by the providers that received the payments.

1 Also, lump-sum supplemental payments to providers may significantly increase the total amount of
2 Medicaid payment that providers receive and we've seen that these account for more than half of total fee
3 for service Medicaid payments to hospitals in some States. However, consistent Federal data on both of
4 these things are generally unavailable at the provider level.
5 Interestingly, we heard yesterday even about the challenges that these things can create for payment
6 policy decisions at the State level, as one of the CHIP directors talked about some of the complications in
7 analyzing them even within their State.
8 So following the discussion at our September meeting, we decided to focus on the supplemental
9 payments for this initial round of discussion of policy options. As we talked about in that meeting, it's
10 generally not possible to determine the exact portion of Medicaid payment that's financed with things like
11 provider taxes. Unless it's explicitly stated in State law or in some other policy documentation, the ultimate
12 use of things like healthcare relate taxes isn't clear. So as a result, the remainder of this presentation's going
13 to focus on these non-DSH supplemental payments.
14 Generally speaking for purposes of oversight and program integrity in the Medicaid program,
15 Federal and State Medicaid policymakers want to understand what the program is purchasing and for what
16 amount. Policymakers throughout the healthcare industry commonly assess payments for their consistency
17 with efficiency and economy, their effect on access to services, et cetera, but the wide variation in State
18 Medicaid payment policies combined with limitations in the data that we have at the Federal level mean that
19 Federal data sources aren't sufficient for analysis of Medicaid payment at the State or the provider level.
20 It is, of course, important to point out before we get into some of the possible options that any
21 Federal policy requirements typically require administrative effort both on the part of the State and on the
22 Federal Government and when considering options, we have to be sensitive not only to this administrative
23 effort, but also the potential effects that any option may have on the flexibility that the Medicaid statute
24 affords to States.
25 So Option One is a -- would be a requirement that CMS collect non-DSH supplemental payment

1 data at the provider level and to make those data publicly available. This option is consistent with a GAO
2 recommendation that CMS issue facility-specific reporting requirements for non-DSH supplemental
3 payments and that such payments should be subject to an annual independent audit, much in the way that
4 DSH payments are now.
5 Kept in mind that States are expected to report non-DSH supplemental payments by type of service
6 on their CMS-64 report, a quarterly expenditure report, but this is only done in the aggregate, not at the
7 provider level. Some non-DSH supplemental payment data is collected at the provider level through the
8 DSH audits, but that's only for hospitals that receive DSH payments and that data becomes publicly
9 available years after the payments are actually made.
10 More recent guidance from CMS is going to require States to demonstrate compliance with the
11 upper payment limit regulations that includes reporting of non-DSH supplemental payments. But at this
12 time, there's not a consistently-required reporting format and we don't expect that those data are going to be
13 made sort of generally or readily available for analysis.
14 We have to acknowledge that additional data collection would, of course, require some additional
15 effort on the part of States. However, because they make these payments based on the requirements spelled
16 out in their Medicaid State plan and they make the payments to enrolled Medicaid providers, we think it
17 shouldn't be overly burdensome necessarily to provide the data in some sort of consistent fashion.
18 One potential vehicle for the collection of supplemental payment data could possibly be the
19 Medicaid Statistical Information System, or MSIS. As you'll recall from past sessions that we've done on
20 Medicaid data, MSIS is a Federal data source compiled by CMS and has detailed enrollment and claims
21 payment data. MSIS is required -- States are required to submit payment data to the MSIS by statute. MSIS
22 is capable of collecting supplemental payment data today. However, the actual collection of data at the
23 Federal level hasn't been a point of emphasis and currently, we see a number of States don't appear to
24 reporting -- to be reporting the supplemental data through MSIS.
25 The Commission has also heard about a CMS effort to expand and enhance MSIS known as "T-

1 MSIS" and CMS has added the submission of T-MSIS as a requirement for receiving Federal match for their
2 IT systems. It remains to be seen, however, whether CMS will emphasize the requirement to submit
3 supplemental payment data through T-MSIS similar to MSIS.
4 This option wouldn't be expected to have a direct effect on medical assistance spending. It could
5 result in some required changes to IT systems at the State level, some increased staff resources to actually
6 report the payment data to the Federal Government. But as I mention, MSIS currently has the capability to
7 accept records for supplemental payments, which should mitigate some of the administrative burden.
8 A second option for consideration could be some sort of requirement that lump-sum non-DSH
9 supplemental payments be for an "approved purpose" that's defined as consistent with the Medicaid
10 program. The mechanisms for targeting these payments vary by State as does everything in the Medicaid
11 program, but non-DSH supplemental payments generally are allocated based on the relative number of
12 Medicaid days that a provider provides, or the number of discharges that a provider has, or as an equal share
13 of some sort of a fixed amount. But recall that there's no limit on the amount of non-DSH supplemental
14 payments that an individual provider can receive, as long as in the aggregate these payments are under the
15 UPL. And because the payments are made in lump sums, they can't be tied to particular services or
16 enrollees or specific policy goals. As a result, their use beyond supplementing lower payment rates and their
17 effectiveness in promoting program objectives can be difficult for us to discern.
18 These payments do require approval by CMS as part of the State plan amendment approval process
19 and it would appear that these relatively-common supplemental payment methods like those based on
20 Medicaid volume among a group of providers are approvable. However, other than broad requirements for
21 Medicaid payments generally, there don't appear to be specific standards related to non-DSH supplemental
22 payments and the Commission might want to consider whether lump-sum supplemental payments, which
23 we know account for over $20 billion in Medicaid spending annually, but aren't associated with specific
24 individuals or services, might be held to a higher standard or level of accountability. Establishing
25 parameters for their use could help ensure that they're consistent with Medicaid payment objectives.

1 A requirement such as this wouldn't be expected in itself to have a fiscal impact on States or the
2 Federal Government, though it is possible that some States would restructure their existing payment
3 methodologies to build some of these things into their rates and that could have, of course, effects
4 ultimately on levels of spending. Also establishing and overseeing the process for approval and monitoring
5 of the use of non-DSH supplemental payments would probably require a significant administrative effort on
6 the part of both CMS and the States.
7 One approach to doing something like this would be to use some of the recent Section 1115
8 demonstrations that we've talked about here as models. You'll remember that the UPL is based on fee-for-
9 service services only, so if States look to shift their fee-for-service into Medicaid-managed care, there's less
10 room under the UPL and they have less ability to make these payments.
11 In permitting States to continue to make non-DSH supplemental payments under these 1115
12 demonstrations, they've worked with States and Texas is an example that we heard about directly from the
13 former Texas Medicaid Director. CMS and the States have tried to identify acceptable uses for the
14 supplemental payments that are consistent with the goals of the program and they're contingent upon both
15 the providers and the State meeting specific milestones and metrics that are spelled out in advance.
16 Yet, another option would be to even consider a prohibition on lump-sum non-DSH supplemental
17 payments, instead requiring that all Medicaid payments have to be tied to specific services or enrollees. As
18 we've heard about, at least one State's in the process of incorporating their supplemental payments into their
19 hospital rates, as required by their State Legislature, and an FAQ document that I came across on the State's
20 website notes -- and I'll quote this -- "Reimbursement methods that are tied to the delivery of services and
21 based on acuity will help to promote high-quality healthcare delivery and appropriate access to care and
22 allow the Department and the hospitals to be more accountable for how the tax resources are spent."
23 As we've noted many times, however, supplemental payments can be a very large component of
24 Medicaid revenue in certain States and for certain providers, especially hospitals. And institutional classes of
25 providers, again specifically hospitals and nursing facilities as well, are often very invested in the payment

1 approach that a State has taken. This is a major consideration for State lawmakers and the inability to make
2 payments outside of regular fee-for-service rates would impose a significant limit on States' flexibility to
3 design their payment methodologies.

4 The fiscal impact of this option's difficult to predict. It necessarily depends on States' responses to
5 the new requirement, so simply saying that non-DSH supplemental payments can't be made, if we say
6 there's about $20 billion in those payments, that doesn't mean this automatically translates to

7 $20 billion in some sort of savings. More likely, States would work hard to figure out ways to build
8 these payments into their payment rates.

9 A further note, this option and probably the option before it would almost definitely require some
10 sort of a phase-in strategy. Modifying payment methods is often a multiyear process and certainly could not
11 happen quickly.

12 Finally, another option is: not to pursue any of the other options that I presented, but rather simply
13 to continue to monitor the use of non-DSH supplemental payments and support efforts to improve
14 reporting and transparency at the Federal level. This would clearly result in no additional administrative
15 requirements for States or CMS, no required changes to existing payment methodologies, no real cost
16 implications. But the Commission could continue to monitor trends in aggregate spending, the submission
17 of State plan amendments, to implement new or to revise existing supplemental payments.

18 On the other hand, as long as provider-specific payment data aren't available, we and other
19 policymakers wouldn't be able to determine the full amount of Medicaid payment to individual providers
20 and, therefore, we would continue to be unavailable to fully analyze the effect of Medicaid payment policies
21 on things like efficiency, economy and quality.

22 So again, all these options are rather broadly stated and they don't represent the entire universe of
23 potential options regarding Medicaid non-DSH supplemental payments. I say here none is expected to have
24 a direct fiscal impact on Federal or State Medicaid spending and, as I just explained, that's because the
25 requirement themself wouldn't necessarily result in more or less spending. It would likely be the sort of

1 downstream decisions that States would have to make in response. The options are not necessarily mutually
2 exclusive. We could emphasize reporting at the Federal level while also calling for the establishment of
3 some sort of parameters. And we look forward to your feedback overall regarding the merits of each of
4 these options and where you think more work might be necessary.

5 CHAIR ROWLAND: Thank you. Trish, David, Denise and Richard.

6 VICE CHAIR SUNDWALL: Trish, you're first.

7 COMMISSIONER RILEY: Oh, thank you. I -- thank you. I think this is a really important and
8 quite complicated, not that everything else isn't, issue for us, but I think it's important that we pursue it for
9 two reasons. One is: it's fundamental to our mission. We need to be able to say something about payment
10 in the Medicaid program and payment and its link to access, and we know that we can't make comparable
11 analyses State by State unless and until we know how these supplemental payments actually affect rates.

12 It's particularly concerning since we've all sat in Medicaid chairs, those of us who have, and been
13 pretty fiercely attacked by hospitals and nursing facilities for underpaying them and I think, you know, given
14 $20 billion of spending where we don't know where it's going, I -- you know, how do we, as a MACPAC,
15 make a determination. So I think it's terribly important.

16 I think it's also important for the States as they have moved so aggressively to think about payment
17 reform. How do you reform a payment structure if you don't have a better grasp of what you're paying for?
18 That said, I think I would like to hear from CMS and the States directly about how this could all play out.
19 And I don't think -- I think for me, the -- these options are mutually exclusive because I think Option Two
20 and Three make assumptions that we don't know until we pursue Option One that we really need more
21 information about how the supplemental payments are reflected at the provider level and in -- and once we
22 know that, then I think we're in a better position to make judgments about how they ought to be spent. But
23 until we know that, I would be reluctant to do Two or Three.

24 And I also think as thorny as this topic is, we clearly are not talking about how revenues are
25 generated, States have a variety of options to generate revenues, but how they're spent. And so I think it's

1 really, really important for us to continue. So Option Four, I don't think, is one for us either. But I would
2 feel comfortable -- personally with Option One particularly if we could get a group of State folks and CMS
3 to sort of think through what it would take to really achieve that transparency.
4 VICE CHAIR SUNDWALL: Now, I'm -- actually, I'm thinking along the same lines. And thanks,
5 Jim, you've -- become the resident expert on this important topic. I liked your presentation last March and
6 where you kind of broke down the categories that I think was really informative for me whether it be
7 intergovernmental transfers or provider taxes or DSH payments or whatever, but I think if we're going to
8 require data, we ought to give some framework to CMS or maybe we do that and -- because I'd like those
9 categories so we'd know and it's be the four or five categories and "other," but as we know, the States have
10 been very creative and -- at least some States have in maximizing their payments. But I think the data really
11 would be valuable, but I would like it organized in a way that it's readily understandable and what it's spent
12 for, if we can get it.
13 COMMISSIONER HENNING: So I guess I'm with Trish. I think that Option One we definitely
14 need because if we don't have Option One, we're not going to know anything because we don't know
15 anything now because we don't have the correct data to make decisions with. So Option One, to me, seems
16 like to make the most sense.
17 Option Two and Three, I don't think there's any way we have enough information at this point to
18 go there, although as a broad overall goal, Option Two sounds good, but I'd still like to have Option One.
19 That has to come first.
20 And Option Four, I really don't think that that's an option because we do need to know more about
21 these payments, so we're -- and we're never going to know more about payments unless we do Option One.
22 COMMISSIONER HOYT: Thanks, Jim, a great presentation, a very difficult issue that for those of
23 us who have struggled with this in different -- wearing different hats over the years, I think it may only be
24 second to finding a single assessment tool for long-term care and difficulty in solving this.
25 [Laughter.]

1 So I won't go to the merits. But I was just curious. The 1115 waivers where you said there was
2 identified acceptable uses, I'm just curious. Can you give -- you know, is that something we're going to have
3 to look into and document or is there -- can you give us some sense of what has been approved in the 1115
4 waivers --
5 MR. TEISL: Yeah, I --
6 COMMISSIONER HOYT: -- as acceptable use?
7 MR. TEISL: I don't know how quickly I can turn to the examples that are in Texas, but they're in
8 some of the background reading that we gave you today. So they fall into sort of very broad categories
9 about infrastructure improvements or improvements to data collection systems. And then within each of
10 these broad categories, are many, many different sort of initiatives that could potentially be funded through
11 the supplemental payments. And then for each of these different initiatives or opportunities, there are
12 spelled out milestones and metrics that would have to be met in order for the payments to continue to flow.
13 But the range is very broad but agreed to in advance.
14 COMMISSIONER HOYT: Is there -- you're like talking about infrastructure improvements, it's
15 like things and buildings, anything with quality performance or outcomes, to your knowledge being tied to
16 supplemental payments?
17 MR. TEISL: Yeah, absolutely. And I can't off the top of my head --
18 COMMISSIONER HOYT: That's okay.
19 MR. TEISL: -- give you a specific example --
20 COMMISSIONER HOYT: Go ahead.
21 MR. TEISL: -- but quality improvements are -- definitely run throughout the different options --
22 COMMISSIONER HOYT: Okay.
23 MR. TEISL: -- that are available, not only in Texas but in other States --
24 UNIDENTIFIED SPEAKER: Yeah.
25 MR. TEISL: -- that have pursued --

1 COMMISSIONER HOYT: Okay.

2 MR. TEISL: -- these sort of approaches.

3 COMMISSIONER HOYT: Thanks, Jim.

4 EXECUTIVE DIRECTOR SCHWARTZ: And the document protects us. I mean, it's like 700
5 pages long, right, of the milestones and the measurements for each of these. They're options for -- that they
6 could choose. I mean, it's not 700 pages of requirements, but it's very explicit. And I think the one in the
7 paper talks about if you're goal was on reducing inappropriate emergency room use, how you would use the
8 money to do that and then how you would measure the effectiveness of your doing it, so it's pretty specific.

9 COMMISSIONER HOYT: Is there -- so when did the Texas waiver go into effect, was it last year
10 or --

11 MR. TEISL: It was approved two years ago.

12 COMMISSIONER HOYT: Okay. So is there reporting on those -- meeting those objectives? I
13 mean, is that laid out in the 700 pages?

14 MR. TEISL: I haven't been able to find reporting on the results at this point. What I -- I was able
15 to find -- they posted some of the plans that their Regional Health Partnerships have put forward for how
16 they were going to use them. I think one I opened was 1300 pages long.

17 [Laughter.]

18 But I haven't yet seen that they've posted results.

19 COMMISSIONER HOYT: Okay. It'd be something to see if we can figure out as -- and even what
20 a timeline is that would -- when we might have expectations actually starting to see something. It'd be great
21 to know. Thanks.

22 COMMISSIONER COHEN: Thanks, Jim, for a great presentation and great work in a really -- in a
23 tough area. I think a major sort of refining of the work since we last discussed this is really focusing, as
24 Trish said, on payment and sort of disaggregating that from the question of like where does money come
25 from and that kind of an issue, which may at some time -- at some future point, be an appropriate topic for

1 this Commission although I'll tell you I'm not sure -- I'm not exactly sure that it is as much payment,
2 however, as very much in our name and in our mission and I think critical.
3 Going through the options, I'm very -- I would be very hesitant for us to sort of summarily suggest
4 that there's an easy definition of kind of what's an "appropriate use" under Medicaid, and I definitely would
5 not use the 1115 waivers as sort of the source for that simply because those waivers are sort of -- they
6 reflect sort of agreed-upon projects appropriate for a given State to move a ball in a particular direction and
7 I think that CMS has been really clear what might be appropriate in one State might not be appropriate in
8 another. They're not written as sort of broad things. They're written as very specific areas. So I don't think
9 that's a good source.
10 I don't think the statute necessarily lays it out all that clearly either, so I think we are far from ready
11 to suggest that we could limit the payments to an "appropriate use" because I think we are nowhere near
12 having a real definition for what that could and should be.
13 Similarly, I think the idea of prohibiting something that we don't at all understand but is, obviously,
14 quite fundamental to the program just because of their uses is way beyond where we are at this point and
15 what we know.
16 I think the transparency in the reporting is an appropriate step for us to take in an area that's sort of
17 so central to our mission. I will say, you know, we headed down this path of thinking about data -- more
18 data and more reporting in the past and I think one thing that we have been really clear about is that, if
19 we're going to ask for data which causes a burden, we are going to be crystal clear what we want it for and
20 that it's actually going to be used. And so while it might be something that CMS would look at, maybe they
21 look at it already, it might be something that external, you know, researchers would be interested in. I think
22 we need to have the commitment that it's something that we really will look at and that the -- and be very
23 clear in our chapter and our explanation what the purpose is.
24 And the purpose is to say -- is to understand if payments go to certain providers, you know,
25 institutional or otherwise, and understand how that relates to the rest of the providers or entities that are

1 getting the money and what -- whether that additional -- withhold additional payments have any relationship
2 to, you know, quality of services, access or other things and sort of analyzing what the payments sort of
3 appear to be providing.

4 And I think that's -- we have to be really clear about that purpose. I'm not sure I've stated it very
5 well, so we will want to look at that really carefully. But I think that that is like an essential piece of the sort
6 of recommendation and the sort of Commission's commitment and it's not -- this isn't asking for
7 information for the sake of asking for information, and it's also not like wide open. We'll see what we get.
8 You know, we really -- we have a mission to understand how payment affects efficiency and quality and
9 access.

10 CHAIR ROWLAND: Judy.

11 COMMISSIONER MOORE: Thanks, Jim. This is really, really helpful. And I think -- and we hear
12 a lot of folks talking about agreeing with the need for additional transparency. I would like for you to kind
13 of say more and remind me about the reporting requirement under TMSIS/MSIS that has not been
14 enforced and the degree to which that includes facility-specific reporting, as you indicated, GAO had
15 recommended or if those are separable or what -- I just don't remember exactly what's in the reporting
16 requirement that's not being enforced.

17 MR. TEISL: Yeah, sure, and I'll give April the opportunity to pop up if she wants to say any more
18 about it. But as you'll recall, the statute requires States to report provider payment data to this Medicaid
19 Statistical Information System. The statute also says that States have to report the data through the system
20 consistent with the requirements as -- you know, put out by the Secretary. There's a data dictionary and
21 there are fields within the MSIS that allow for facility-specific or provider-specific reporting of payments
22 that can be coded as sort of general claims based payments or as supplemental payments. So those fields
23 exist now.

24 In looking at the data, there are a lot of States where we know supplemental payments are being
25 made, but they are not included in the MSIS data and this is sort of further supported by some work that

1 GAO did not too long ago to compare the MSIS to the CMS-64 and they flagged these supplemental
2 payments not being in MSIS as one of the major reasons why MSIS and the CMS-64 don't match up. There
3 are a bunch of other reasons, but that was one of the big ones.

4 So the requirement for the submission of data exists. What I think would be necessary is: emphasis
5 on the part of CMS to require, to, in fact, enforce the completion of this data element in the system.

6 COMMISSIONER CHECKETT: Really, most of my points have been made by my brilliant fellow
7 Commissioners, but I do want to just -- particularly on this Option Two, Jim, on the approved purpose
8 consistent with the goals of the Medicaid program. You know, it seems to me that when you make a
9 payment to a hospital under fee-for-service, you're just paying them.

10 And when you give them a lump sum under -- using DSH or UPL, you're just paying them. And
11 those are actually approved purposes that you -- you know, it's providing a service or something like that,
12 but I am really interested in the 1115 language and other options that I think start to get at the idea, but I
13 would separate it. I don't think it's whether or not those payments are making -- how do I want to say it?
14 That it's for an approved purpose when I actually went back and looked more closely at your report. It's
15 linking a payment to an outcome. And so I think as we phrase these options, let's pull that point out
16 because that's actually what they've done, which I think is very interesting and actually ties in with what
17 we're trying to do in terms of, you know, some loose payment reform or some sense of outcomes and
18 accountability so -- but it is really an interesting idea.

19 I completely agree that, you know, first and foremost for us to look at is just more transparency
20 about, you know, what is being paid to whom, and then I think certainly to take the next look at do we start
21 to say we need to link those payments to some type of outcome? So -- but thank you again for your work
22 on this.

23 COMMISSIONER HOYT: My recollection is that the 64 reports are that they're on a cash basis,
24 cash money disbursed by quarter. So my concern around -- I'm in favor of Option One, like everybody else
25 -- is that once you get the lump sums of money by provider, I would think next we're going to want to tie it

1 to something else like utilization days, admits, something if we don't have -- what I'd like is accrual data so
2 I'd try to weave that into the recommendation if we can. And unless I'm missing something, that's just like
3 impossible for the providers. I'm still not sure we'll have something that's really all that telling or useful if
4 we just get cash disbursements even by provider by quarter. Let's look a little bit past that. What else are
5 we going to connect it to and make sure we really can drill down to something useful.
6 MR. TEISL: Yeah. I think -- just to respond in part to that. I mean, I -- theoretically, what we
7 might like to be able to do is to get those payments by provider and by quarter and be able to marry those
8 data to what we already have in the MSIS, which are claims data, again in the fee-for-service world, for those
9 same time periods so we would have some sort of a utilization metric that would be at least for a common
10 time period as the supplemental payment data.
11 CHAIR ROWLAND: Jim, as a longer range thing, I think it's also important to recognize that this
12 is all part of the fee-for-service world of Medicaid and as we're shifting more into managed care, which is a
13 lot of what was going on in the Texas waiver application, how does this play out? I mean, where do we end
14 up with supplemental payments in a more and more managed care environment and how important is it to
15 know where they are now so that you can figure out what the transition is?
16 But I think that's part of the bigger picture of why we want more information and why we want to
17 be able to understand more how that works with at the provider level as she shift the way in which the
18 delivery system is working overall in the Medicaid program. Okay. Well, thank you for really leading us
19 through a complex area. It's always tough to talk about payment policy, but you've done a great job of
20 helping to set out some of the issues we want to look at, so thank you.
21 MR. TEISL: Thank you.
22 CHAIR ROWLAND: And now, if anyone from the public has a comment they'd like to make,
23 please come to the mic and identify yourself and offer us your comment.
24 **### PUBLIC COMMENT**
25 MR. KNAPP: Hello? Okay. Thank you. Hi, I'm John Knapp. I'm with the Children's Hospital

1 Association. Thank you for the opportunity to speak today. The Association joins with other children's
2 health care organizations to express our support for continuing CHIP, and we thank the Commission for
3 discussing the role of CHIP in meeting the needs of kids. CHIP represents a national investment of
4 children's healthcare that predates the Affordable Care Act and CHIP benefits, provider networks, and cost-
5 sharing protections are designed with children's needs in mind. The 2009 CHIP reauthorization also
6 included the first significant national investments in children's healthcare quality.

7 We are concerned the exchanges do not reflect children's unique healthcare needs. While the
8 Association will continue to advocate for improved policies and exchanges for children, it is particularly
9 important that CHIP, along with Medicaid, continues to be an important source of coverage for kids. This
10 will ensure children have access to provider networks and benefits that support their continuous growth and
11 development.

12 It's also essential to continue the important initiatives in pediatric quality. We will be providing a
13 more-detailed statement and comments to in written to the Commission. And again, thank you for the
14 opportunity to speak today and your attention to CHIP, and we look forward to working with you.

15 CHAIR ROWLAND: Thank you. And we welcome your additional comments and we'll make sure
16 that they get to all the Commission Members when submitted. Thank you.

17 MR. KNAPP: Thank you.

18 MR. BUSHMAN: Good afternoon. My name is Jesse Bushman. I'm the Director of Advocacy and
19 Government Affairs with the American College of Nurse-Midwives, and I wanted to make just a couple of
20 comments today and the first one is just in relation to the report that you recently put out that has a chapter
21 on maternity care. I want to thank you guys for taking time to do that and making the effort both with the
22 Commission and the staff to do that. It's an important topic given the fact that Medicaid is covering about
23 half of the births in the country right now.

24 I -- what I want to say about that is just to encourage the Commission to make some specific
25 recommendations around improving the quality of maternity care in the Medicaid programs and I'd point to

1 a couple of things. First, CMS has recently finalized work with an expert panel that they had on maternity
2 care and they had a report that was finished in July. I don't think it's been made publically available yet, but
3 I would encourage the Commission to contact CMS and try to get a hold of that because there are a number
4 of specific recommendations in that report for improving maternity care in the country that I think would
5 be valuable for the Commission to see.

6 And then also wanted to give you a head's up that the American College of Nurse-Midwives in
7 coalition with a number of other organizations is working on a letter with some ideas around
8 recommendations that the Commission could make to address some issues in maternity care, and I just want
9 to let you know that that'll be coming at some point in the future.

10 And the second comment that I want to make is related to the issues around the complexity of
11 coverage for pregnant women and I was glad to see that people were scratching their head about that here
12 because I spent a lot of time trying to figure that out myself and the fact that this group of people has
13 questions and concerns about that, I think is a warning that your average Medicaid beneficiary is going to
14 have very little chance of clearly understanding exactly what her options are under all the possible avenues
15 of coverage and so I do think it's important that the Commission say something about either taking a stance
16 that there should be a single benefit package that's available or a single clear path or at least encouraging the
17 States to really make it clear to those beneficiaries what is available to them.

18 And along those lines, the last thing that I would point out is to take care -- if you recommend that
19 women who are pregnant are covered under a particular benefit package, be careful about what that means,
20 and I would just point out that under the existing Medicaid package of benefits, there's some distinctions
21 between what would be covered under an EHB-based expansion package or something that's offered
22 through the exchanges. For example, the statute does require coverage of birth centers under fee-for-
23 service Medicaid and by extension the Medicaid-managed care plans, but that same requirement is not
24 actually a part of the EHB benefit. It might be if the plan opts to include it. And the similar thing, I think,
25 happens with the requirement for coverage of services of certified nurse-midwives under Medicaid fee-for-

1 service, there's not exactly a guarantee that those kinds of services are covered under the exchange plans.
2 And so I would just encourage you to keep that in mind as -- that there -- the clinical ramifications that you
3 discussed do exist when you point to a particular benefit package. Thank you.
4 CHAIR ROWLAND: Thank you very much, and your comments will be taken into account as we
5 go forward.
6 Other comments? If not, the MACPAC meeting will be adjourned. And we look forward to seeing
7 you back in December when we continue to go through these issues in greater detail. Thank you.
8 [Whereupon, at 12:18 p.m., the meeting was adjourned.]