PUBLIC MEETING

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National Guard Association of the U.S.
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COMMISSIONERS PRESENT:

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

2 [9:48 a.m.]

3 CHAIR ROWLAND: Okay. Good morning. If we could
4 please convene for this session of the Medicaid and CHIP
5 Payment and Access Commission.
6 We're going to start our discussion this morning
7 with an update on the Medicaid disproportionate share
8 hospital payments report that we are required by statute to
9 provide to the Congress by February 1st of this year. This
10 is an annual requirement for us, so I want you to think of
11 this report as the first installment of many. It is
12 really, in my mind, the kind of baseline of where DSH has
13 been, where DSH is today, and what are some of the issues
14 going forward in thinking about not just disproportionate
15 share payments as a dollar value, but what their role is in
16 the health care system and what their role is in
17 maintaining some of the support needed for the remaining
18 uninsured and for the shortfalls that hospitals serving a
19 disproportionate share of Medicaid, as well as other
20 uninsured low-income individuals, face.
21 So, as usual, we're going to turn to Rob and Jim
22 to provide us with an overview of the report, and then I'd

1 like to turn to the -- we asked some of our Commissioners
2 to be particularly on point with their comments to lead our
3 discussion, and then we'll open it up to broader
4 discussion.

5 **### Medicaid Disproportionate Share Hospital**
6 **Payments: Review of Draft Report**

7 * MR. TEISL: Thank you, and good morning,
8 everyone. So, again, our plan today is to provide an
9 overview of our draft report on Medicaid DSH and to
10 consider a potential recommendation for improved data to
11 better inform our Medicaid DSH payment analyses in the
12 future.

13 First, a quick overview of what it is we're
14 talking about in case you haven't been to our previous DSH
15 report sessions.

16 MACPAC is required to submit an annual report to
17 Congress on the relationship of state DSH allotments to the
18 factors listed here in the sub-bullets. And as Diane
19 mentioned, this will be our first baseline report, so in
20 addition to our required analyses, we intend to provide
21 context on the history of Medicaid DSH payments as well as
22 discussion of the data sources that we have available, as

1 well as their limitations.

2 Here is a high-level outline of what our draft
3 report includes now. We begin, as mentioned, with a
4 chapter on the history and the current context for Medicaid
5 DSH payments. Chapter 2 includes discussion of how the
6 factors that we're required to consider are changing as a
7 result of coverage expansion and how state DSH allotments
8 relate to these factors. We conclude with a chapter on the
9 data issues that challenge our ability to analyze Medicaid
10 DSH payments, as well as some of the policy approaches that
11 the Commission might consider as we move forward with our
12 work on DSH and towards future reports. We'll talk about
13 each of these chapters in a little more depth in a moment.

14 I should mention we also plan to include several
15 appendices. The first is a legislative timeline. We
16 intend to include one with a lot of data on state-level DSH
17 allotments as well as payments to specific types of
18 hospitals and a third that will have some discussion of our
19 methods.

20 Chapter 1, we start with some of the history of
21 Medicaid DSH payment policy, and the idea of DSH payments
22 emerged in the early 1980s after states were no longer

1 required to pay hospitals based on their reported costs.
2 There was concern at the time that decreases in
3 Medicaid rates could jeopardize certain hospitals,
4 particularly those that served high numbers of low-income
5 patients. And so Congress required that states take into
6 account the situation of these hospitals when they set
7 their rates. Soon after, Congress took the step of
8 actually requiring states to make DSH payments to certain
9 hospitals.
10 Then in the early 1990s, Congress became
11 concerned by the rapid rate of growth in the DSH payments
12 that states were making, and so they enacted state- and
13 hospital-specific limits on DSH spending. States' limits
14 were based on the amount that they were spending on DSH at
15 the time, and those amounts varied widely. These early
16 1990s spending levels, if you sort of trace the legislation
17 all the way back, still serve as the basis for most states'
18 allotments today. So as a result, we have state DSH
19 allotments that range from around $10 million in some
20 states to more than $1 billion in other states.
21 In addition to the history of Medicaid DSH, our
22 first chapter will cover the current state of DSH spending

1 and the wide variation across states. For example, while
2 about half of U.S. hospitals receive DSH payments, several
3 states make payments to only a hospital or two, while
4 others make payments to nearly all their hospitals.
5 This first chapter will also discuss some of the
6 other sources of support for hospitals, including other
7 supplemental payments under Medicaid, Medicare DSH
8 payments, as well as things like tax exemptions.
9 We also discussed the characteristics of so-
10 called deemed DSH hospitals which serve the highest numbers
11 of low-income patients and are actually required by the
12 statute to receive DSH payments. Based on our analyses,
13 DSH payments looked to be an especially important source of
14 revenue to these deemed hospitals.
15 Finally, we discussed the fact that under the ACA
16 Medicaid DSH allotments were scheduled to be reduced,
17 initially beginning in FY2014, based on the idea that
18 increased health coverage would reduce the need for these
19 payments. The reductions have been delayed several times
20 and are now scheduled to begin in fiscal year 2018. And
21 for what it's worth, one of the more recent bills that
22 delayed the reductions also included the requirement for

1 MACPAC's annual report.

2 So I'll hand it over to Rob now, who will walk
3 through the other two chapters and set up our draft
4 recommendation language.

5 * MR. NELB: Thanks, Jim.

6 So in the second chapter, we really dive into the
7 meat of our analysis and provide the various data that
8 Congress asked for us to include in this report. We begin
9 by reviewing changes in the number of uninsured individuals
10 in 2014 using data from the American Community Survey.
11 Overall, all states saw declines in their uninsured rates
12 in 2014. But states that expanded Medicaid saw the
13 greatest declines on average.

14 Then we reviewed changes in the amounts of
15 hospitals' uncompensated care using available data. We
16 don't yet have complete data on the effects of the ACA on
17 uncompensated care. We review early reports from a variety
18 of studies that suggest that unpaid costs of care for the
19 uninsured is declining, particularly in states that have
20 expanded Medicaid.

21 We complemented our review of the literature with
22 our own analysis of hospitals that have submitted complete

1 2014 Medicaid cost reports, and we found similar results.
2 However, without complete data on all hospitals, it is not
3 yet clear how that subset of hospitals that is particularly
4 reliant on DSH payments are being affected.
5 Third, we provide data on hospitals with high
6 levels of uncompensated care that also provide essential
7 community services. As you'll recall, this is a
8 requirement of our statute, but the term "essential
9 community services" isn't defined anywhere else in statute
10 or regulation. As a result, we came up with a working
11 definition for our analyses that started with the
12 definition of "deemed DSH hospitals" that Jim described.
13 And then we looked at the extent to which those hospitals
14 provided at least one of a variety of essential services
15 that we identified based on available data. Overall, about
16 700 hospitals met our working definition, which is about
17 nine out of ten deemed DSH hospitals.
18 We conclude this chapter by projecting state DSH
19 allotments, including state DSH allotment reductions for
20 2018. Using our model, we also looked at how states might
21 respond to the incentives included in the DSH allotment
22 reduction formula and estimate DSH allotment reductions if

1 all states expanded Medicaid, which overall is relatively
2 similar to the status quo projections.
3 In addition to projecting state DSH allotments,
4 Congress required us to examine the relationship between
5 these DSH allotments and the other factors identified by
6 Congress.
7 In short, we find that there's little meaningful
8 relationship between the state allotments and these
9 factors, even after applying DSH allotments reductions.
10 This is not surprising since, as Jim mentioned, state DSH
11 allotments are largely based on state historical spending.
12 But the range in state DSH allotments is quite large.
13 For example, in terms of the number of uninsured
14 individuals, state DSH allotment per uninsured individual
15 ranged from $3 in some states to more than $1,500 in other
16 states.
17 In terms of hospitals' uncompensated care costs,
18 we found that some states have DSH allotments that are
19 larger than the total amount of uncompensated care in the
20 state, as reported on Medicare cost reports, while other
21 states have DSH allotments that are less than 10 percent of
22 the uncompensated care in their state.

1 And, finally, when we looked at the number of
2 hospitals with high levels of uncompensated care that also
3 provided essential community services, we found no
4 relationship with the state DSH allotments either.
5 Overall, this analysis suggests that state DSH
6 allotments could be better targeted based on more objective
7 measures of need.
8 After reviewing the required data elements, our
9 final chapter provides a discussion of data limitations and
10 opportunities to improve data to help better targeting of
11 DSH payments moving forward.
12 Overall, we find that by far one of our most
13 significant data limitations is the lack of complete and
14 timely data on Medicaid shortfall for all hospitals. We
15 currently don't have complete data on all supplemental
16 payments that hospitals receive, and we don't have any
17 provider level data on provider contributions towards the
18 non-federal share which affects the net payments that a
19 provider receives. And without this complete net payment
20 data, we simply can't get a full picture of existing
21 Medicaid payments to providers, which is important to begin
22 to understand the provider's need for DSH payments.

1 In addition, the data that we do have on hospital
2 payments is not very timely, and in the case of DSH audits,
3 it is as much as five years old.
4 Because of the importance of this Medicaid
5 payment data, for this DSH work as well as other payment
6 work that we're engaged in, we have drafted a potential
7 data recommendation about this issue, which we'll discuss
8 later. It's for your consideration.
9 In this chapter, we also highlight other data
10 issues that affect our ability to analyze the targeting of
11 DSH payments, which are ones that we hope to explore
12 further in future reports. Examples include measuring
13 Medicaid utilization for dual-eligible beneficiaries,
14 tracking other sources of funding for uncompensated care,
15 and better understanding the relationship of DSH payments
16 to community benefit expenditures reported by nonprofit
17 hospitals.
18 Now, unlike Medicaid shortfall, where there
19 simply isn't any complete or timely data that we can
20 analyze, these data issues are ones where there is data
21 available out there, but we just haven't been able to fully
22 examine it and link it with the DSH data we've collected.

1 So, for example, with the community benefit expenditures,
2 which you all have discussed, we do have data from the IRS
3 about community benefit that has been reported, but we just
4 haven't been able to link that data with DSH audits to see
5 how they compare. And so this is on our agenda as a topic
6 for analysis in future reports.
7 Now, because, as I mentioned, this is the first
8 of many annual reports on Medicaid DSH that we will be
9 preparing, we conclude our report with a discussion of next
10 steps for future analysis. In particular, we hope to be
11 able to say more in future years about the effects of the
12 ACA on hospital uncompensated care and its implications for
13 DSH policy.
14 In addition, the report also outlines three broad
15 policy approaches for improving the targeting of DSH
16 funding, which we also hope to explore: first, modifying
17 the minimum provider eligibility criteria for DSH payments;
18 second, redefining eligible uncompensated care costs, which
19 would affect the total amount of DSH funding that a
20 particular hospital could receive; and, finally, exploring
21 opportunities to base state DSH allotments based on more
22 objective criteria.

1 So that is a high-level summary of the content of
2 the draft report. Jim and I are happy to answer any
3 questions. I'll conclude, though, with the text of the
4 draft data recommendation that we've prepared for your
5 consideration today. This proposed recommendation builds
6 off of the Commission's prior recommendation that the
7 Secretary collect and report non-DSH supplemental payment
8 data, and more information about the rationale for the
9 recommendation is in your materials on page 3-10.
10 Again, Jim and I are happy to answer any
11 questions, but mostly we'll try to be good listeners and
12 incorporate your feedback into the final report. Thanks.
13 CHAIR ROWLAND: Let me clarify something about
14 the data issues in the draft recommendation. While these
15 data issues are important to us to be able to do the work
16 Congress has asked us to do in looking and examining DSH
17 policy, we will proceed with our work in the absence of
18 this data as best we can. But in addition to that, the
19 reason for these data requests are more that, going
20 forward, anyone shaping future policy for DSH would need
21 such data to be able to do the effective targeting. Is
22 that not correct?

1 MR. NELB: Yes, that's absolutely right.
2 CHAIR ROWLAND: Okay. I'm going to turn--we've
3 asked three of our Commission members to step into the fray
4 first on discussing this chapter, and I'm going to turn
5 first to Patty, then to Sheldon, and then to Chuck.
6 COMMISSIONER GABOW: Thanks. As you know,
7 there's nothing more exciting than reading a DSH report.
8 But, seriously, I'm someone who ran a large safety net
9 system that cared for the majority of the Medicaid patients
10 in Denver and a majority of the uninsured in the state. It
11 is clear that DSH is critical to sustaining the safety net
12 and, therefore, the care for a large majority of Medicaid
13 and uninsured patients.
14 I thought the report was excellent. I thought
15 the tone was appropriate. I thought the use of data that's
16 available was very good. Points for what data is needed to
17 really be transparent and accountable were well pointed
18 out, and I support the recommendations.
19 I would say for the executive summary a number of
20 the "wow" statements that are buried in the report just
21 don't come out, and I think some of these are what you've
22 mentioned. We find that there is little meaningful

1 relationship between DSH allotments and any of the factors
2 Congress required us to consider, even under a reduction
3 scenario. And that our analysis of current DSH allotments
4 found wide variation across states in the level and
5 distribution of DSH payments that have little meaningful
6 relationship to the measures meant to identify those safety
7 net institutions most in need, including the number of
8 uninsured in the state. I think those are pretty startling
9 observations that deserve to be underscored more
10 prominently.

11 And I would also say that another observation
12 that deserves to be underscored is that more than 30
13 percent of all the DSH payments went to hospitals that
14 would not qualify under Federal standards as a deemed
15 hospital. So the original intent, we're spending a fair
16 amount of money on a group of institutions that would not
17 have met the original intent. So I think those deserve to
18 be front and center.

19 I also wanted to comment about the essential
20 community service. I think it was good to include that. I
21 think the benchmark of one essential community service is
22 probably too low a benchmark. I would like to see a higher

1 number, whether it is three or -- I mean, you know, it's
2 going to be arbitrary no matter what number, but one you
3 can sort of almost do in passing. The more you do, the
4 greater your commitment really represents as an essential
5 community provider, and it might be -- I don't know if it's
6 possible to look at what the relationship is between DSH
7 payments and number of essential community services, but I
8 think one is too low a target.
9 And my last comment is I wonder if it's worth
10 trying to think about if the targeting to the uninsured was
11 not the uninsured in the state but the uninsured in a given
12 hospital or system level -- and I do think the move from
13 looking at individual hospitals to system, if you have a
14 hospital that's part of a system and that hospital system
15 has a large bottom line, then is that DSH payment
16 appropriate? So I guess I do have one other comment, which
17 is, how does DSH payment align with profitability not only
18 in individual hospitals but with the system in which some
19 of those were embedded? Because I think it really was
20 intended to support those who wouldn't be functional
21 without this payment because of their services and to
22 provide it, and if a system is making 15 percent bottom

1 line and members of the system are still getting DSH
2 payment, one would wonder if that fulfills the original
3 intent.
4 So those are my comments. Congratulations on a
5 good job on a complex topic.
6 CHAIR ROWLAND: Thank you, Patty. Sheldon?
7 COMMISSIONER RETCHIN: Thanks. I appreciate the
8 opportunity to review the report, which is incredibly well
9 done. And I agree with the recommendations. Let me just
10 make a couple of comments.
11 First, I guess what continues to strike me and
12 maybe the other Commissioners as well are these remarkable
13 variations in the way DSH payments are allotted.
14 The statement on the non-meaningful relationship
15 between, I guess, the formulas used for DSH payments that -
16 - maybe I was confused by the statement. You are nodding
17 vigorously. Were you just nodding vigorously that I'm
18 confused or about the --
19 [Laughter.]
20 COMMISSIONER RETCHIN: Because as soon as I got
21 to "confused," you started to nod.
22 So was the statement meant to say that there is

1 little meaningful relationship in the way DSH payments are
2 allotted to states or within-state variation or the federal
3 sort of look at it?
4 MR. TEISL: The former. So we were looking at
5 the relationship of state-level DSH allotments to those
6 characteristics.
7 COMMISSIONER RETCHIN: And so I think a little
8 more definition -- I don't want to wordsmith, but my
9 comment back was if you go to Figure 1.2, you'd have a hard
10 time coming away with the idea that there's no meaningful
11 relationship with the way DSH payments are allotted since,
12 while 30 percent of the payments are allotted to those that
13 would be non-deemed -- I don't remember the number, but,
14 let's see, 75 percent, I think, are allotted to those in
15 the 40 percent highest deciles. Is that right?
16 MR. TEISL: Yeah, and that's the distinction
17 between sort of the relationship of state-level allotments
18 to those characteristics being different from then the way
19 that states distribute those allotments to hospitals in
20 their state, in which we did see the majority of DSH
21 payments appear to go to those deemed hospital.
22 COMMISSIONER RETCHIN: So I agree with Patty that

1 -- the figure jumps out at me in two ways, but that 30
2 percent of the payments go to hospitals that would not
3 qualify as deemed DSH hospitals I think tells part of the
4 story. But I guess a bigger part of the story would be to
5 -- there must be even worse spreads in some states the way
6 they're allotted. My only fear there is that if Congress
7 uses that as a way to reduce DSH payments, you may be
8 punishing hospitals that are in those states by an overall
9 reduction if the state doesn't have the will or the sense
10 of responsibility to respond to an incentive to reallocate
11 or target.

12 That's why I favored the approach to look at a
13 different eligibility standard so that it would take a
14 little bit of this away. The politics of states differ,
15 and I think leaving that up to the state politics that
16 might intervene in the way the current payments are
17 allotted would concern me.

18 On essential services, there is one element that
19 I found, I continue to find missing, and that's the open
20 portal that some deemed DSH hospitals or maybe all deemed
21 DSH hospitals have through physician offices. So those
22 like Denver Health and others that employ physicians or

1 large teaching hospitals are seeing uncompensated,
2 undercompensated, I mean, undercovered beneficiaries in
3 greater proportions for non-urgent chronic diseases;
4 whereas, those who may be receiving DSH payments at the
5 lower end of the 30 percent actually benefit two ways:
6 they're getting DSH payments, and yet they don't have open
7 portals. Their portal is really only the emergency room.
8 So I think that as an essential service, some
9 look needs -- there needs to be some consideration of those
10 that either employ physicians or have physicians that
11 participate in the Medicaid program in a broad way.
12 Otherwise, you've got two different approaches that really
13 don't benefit beneficiaries unless they show up in an
14 emergency room and then they get DSH coverage.
15 Remember, in DSH, the "H" stands for hospital, so
16 those hospitals that are better able to use that, that's
17 not being captured in any of these payments, even though
18 outpatient costs are covered, the pro fees and the
19 professional coverages are not.
20 So, and then just a comment. Well, actually one
21 more comment is on the IMDs. I don't -- I guess I was a
22 little surprised in this report, went back and looked, and

1 I guess it just -- it escaped me, maybe, getting back to
2 the confused component. I was taken aback that almost one-
3 fifth of DSH payments go to IMDs, and I don't know whether
4 the considerations on the Hill about IMD exclusion -- will
5 that mitigate in any way the use of DSH? It has to, right?
6 MR. TEISL: It would conceivably affect the
7 facility-specific DSH limit if some proportion of the
8 population that visited that facility that was previously
9 uninsured were able to be paid for by Medicaid.
10 COMMISSIONER RETCHIN: Do you know, though, the
11 types of patients who are being seen that would take that -
12 - this 18.5 percent of DSH payments? Those are evidently
13 Medicaid patients who, because they're going to an IMD --
14 you don't know.
15 MR. TEISL: Well -- it varies by state, I guess,
16 the coverage level. Oh, I'm sorry. I'm just too far from
17 it. It would really vary by state and the different levels
18 of eligibility --
19 COMMISSIONER RETCHIN: Okay.
20 MR. TEISL: -- for those people.
21 COMMISSIONER RETCHIN: And then an issue on the
22 profitability of systems. I understand what Patty is

1 saying, and I guess I would share that concern. The only
2 response I would have would be whether the systems would
3 then in some way or another, because these particular
4 institutions, they're cost shifting now, whether they might
5 be closed as a response. I would worry about unintended
6 consequences. But, I certainly understand what you're
7 saying, the large systems that -- actually, there are other
8 issues there related to 340B and other strategies that are
9 being used, so I certainly understand them. Those are my
10 comments.
11 COMMISSIONER MILLIGAN: So, I do want to echo the
12 comments, the compliments the other folks have made. I
13 thought it was really, really well written. I learned a
14 lot. I've been around this stuff a long time and I learned
15 a lot and I thank you for that.
16 I think I have five comments, but I'll sort of
17 work through them expeditiously, hopefully.
18 The first is, I don't think we adequately
19 describe why DSH is unique, and by that I mean if DSH went
20 away, hypothetically, and states simply raised their
21 Medicaid rates to those hospitals or did a non-DSH
22 supplemental payment, a UPL type of approach, why wouldn't

1 that be sufficient? And by that I mean, what tools does
2 DSH offer that are unique to DSH, because I think in the
3 discussion about how would states respond to DSH cuts 2018
4 and beyond, presumably, one response the public would think
5 is, raise your -- take the state match savings and just
6 raise the base rates.

7 So, I don't think we describe how DSH is
8 unrelated to Medicaid volume, claims. I don't think we
9 describe how it's not limited by the UPL in some ways. I
10 think that that foundation needs to be established to make
11 it clearer what we're talking about that couldn't be
12 addressed in other ways.

13 The second comment is I think we have to be clear
14 about what we mean by uncompensated care, and I think in a
15 lot of the data, charity care and bad debt gets combined.
16 I think of them as very separate things. To me, charity
17 care is care that is written off by a hospital subject to a
18 financial assistance policy generally approved by their
19 board that says, for these income levels and these bills,
20 because of financial need, the hospital will choose to
21 write it off, as opposed to bad debt, which is uncollected
22 or uncollectible, but could involve a lot of high-income

1 people who have high-deductible private insurance plans and
2 the hospital chooses not to chase the $5,000 deductible.
3 To me, that isn't a good -- DSH isn't a good response to
4 the bad debt side. It's a better response to charity care.
5 So, I think we need to be -- or people who are just simply
6 uninsured because they don't have a path to insurance
7 coverage because of documentation or other reasons.
8 I think that -- I want to mention the essential
9 community services comment, as well. I think I would
10 support a recommendation that the Secretary or Congress
11 define essential community services. I think that there's
12 going to be a lot of game-ability and a lot of variability
13 if states can define that, and it becomes a kind of a loose
14 bar that may, if we go down to targeting down the road, may
15 -- how essential community services are defined and who
16 gets to define it may not solve the problem of variability
17 and targeting funds to the wrong place.
18 EXECUTIVE DIRECTOR SCHWARTZ: Chuck, can I just
19 jump in there?
20 COMMISSIONER MILLIGAN: Sure.
21 EXECUTIVE DIRECTOR SCHWARTZ: I just want to
22 clarify that essential community services doesn't have any

1 meaning in the DSH statute. It's simply in this request to
2 us. It was an attempt by the people who are writing that
3 to capture something about the services. So, it's only for
4 us, and so it's really for us to do a better or a worse job
5 of that or to comment on sort of the limitations in trying
6 to do that.
7 So, I just want to make sure that it is a
8 nebulous concept that we've made a first crack at defining,
9 and maybe we can do a little bit better job in the future,
10 but it's complicated.
11 COMMISSIONER MILLIGAN: Thanks. Actually, very
12 helpful, Anne. I'll come back to that kind of in my final
13 pitch here.
14 The -- I wanted -- I guess the next comment I
15 wanted to make was about tax exemption. There's a couple
16 of references in the report to the fact that a lot of
17 hospitals that receive DSH funding also receive tax
18 exemption from the federal government and also state and
19 local governments, and in our previous conversations, we've
20 talked about whether a hospital is -- and I want to be very
21 colloquial about this, getting credit twice for the same
22 uncompensated care, once as a justification for their tax

1 exemption, which has value, and secondly as a justification
2 for a DSH allocation.
3 And, I think that -- a couple points. One is
4 that it's not just nonprofit tax-exempt hospitals that get
5 the tax exemption. It's public hospitals that are
6 exempted. It's not as easy to chase down the data without
7 990s. But, in a lot of places I've worked and consulted
8 over the years, a lot of DSH is going to public university
9 teaching hospitals that are -- so, I just -- I think we
10 have to be thoughtful about how we describe the tax
11 exemption issue and make it clear that it's not just
12 nonprofits we're talking about.
13 And then to close and come back to this essential
14 community services point, if down the road -- and I'm not
15 proposing short-term, but down the road -- MACPAC wants to
16 weigh in on how to target the funds, it seems to me that
17 there are a couple of criteria that we would want the
18 evidence base to be developed, to the extent it's possible.
19 And, so, I'm not proposing that these would be targeting
20 criteria now, but I'm proposing that this would be the
21 evidence base that would be essential to evaluate that
22 later.

1 One is, there has to be -- in my view, there has
2 to be -- if tax exemption and this double counting of --
3 double credit -- if that's going to be a factor for
4 targeting, I think we have to be thoughtful about who has
5 to collect the data, how it has to be collected. Is it
6 HHS? Is it Congress? Who's going to -- is it the state?
7 Who's going to look at, at a hospital level, hospital-
8 specific level, the value of their tax exemption or not?
9 And I don't have an answer to that. But, if that's going
10 to be a targeting factor, it seems to me that we need to
11 think about how to get the data and who's going to have to
12 use the data.
13 And then the second is if the targeting factor is
14 going to be premised on essential community services or
15 some other proxy to have a kind of a second class of deemed
16 hospitals, what that would look like. In other words, if
17 we think DSH funds down the road should be based on a
18 notion of essential community services, I think that we
19 need to be thoughtful about what that means to us, if
20 that's going to be a factor for targeting. And, so, I do
21 think refining that will matter in future discussions.
22 So, I'll leave it there. Thank you.

1 CHAIR ROWLAND: Okay. And we'll try to take all
2 those into account.
3 And now I'll go first to Trish, then to Mark,
4 then to Donna.
5 COMMISSIONER RILEY: Thanks. We're all going to
6 say this. It's a fabulous report. But I want to make it
7 100 pages and not 90.
8 [Laughter.]
9 COMMISSIONER RILEY: I want to talk about -- I
10 want to trigger off what Chuck was just talking about and
11 talk a little bit about the second bullet of the charge --
12 CHAIR ROWLAND: Trish, can you bring the mic a
13 little closer to you or --
14 COMMISSIONER RILEY: Okay. This has never
15 happened to me.
16 The amount and sources of hospital uncompensated
17 care costs. Without getting into the arcane cost versus
18 price charge, it does seem to me that we need to define
19 those terms much more precisely in order to define the so-
20 called Medicaid shortfall and that that has an impact on
21 the budgetary issues here about how we might deal with DSH.
22 Chuck is 100 percent right on the issues of bad

1 debt, not just the underinsured, but the notion of some of
2 it is recovered and how does that show. It's a pretty
3 arcane piece of work. And then at what price is
4 uncompensated care charged, because we know people who
5 experience charity care are usually charged by a hospital
6 at top dollar. They don't have discounts. Now, that's a
7 policy issue that relates to how big the shortfall might
8 be, and I think we need to drill into that a little bit
9 more deeply to fully understand, before we just make a
10 quick decision about, you know, how much the shortfall is.
11 And, I think, to Chuck's point, I would actually
12 say it's a triple dip and that we need to explore this
13 issue again because of the budgetary implications.
14 Hospitals cost shift the so-called Medicaid shortfall to
15 private payers. They claim DSH and they claim the tax
16 exemption. So, I think we just need to drill down to that
17 second bullet a little more and explain the nuances of
18 this, because before we leap to any conclusions about what
19 ought to happen and how much it should be priced or cost,
20 we need to understand that second bullet.
21 CHAIR ROWLAND: Okay. Mark.
22 COMMISSIONER HOYT: Thanks. I thought it was a

1 really good report, as well.

2 I felt like there was another pretty strong,
3 compelling reason for the recommendation for getting the
4 level of detail that we're talking about here that was
5 either missing or was pretty light, and that would be the
6 managed care environment that's present in most of the
7 states. So, as higher and higher percentages of Medicaid
8 eligibles or beneficiaries are enrolled in managed care
9 plans, then the key financial transaction shifts to the
10 contracts that managed care organizations write with
11 hospitals and a state's fee-for-service reimbursement
12 schedule much less so. And if you're at a health plan
13 charged with negotiating hospital rates and you don't
14 understand all these different moving parts, you're just
15 flying blind. There's no way you can rationalize your
16 rates between hospitals in ways that you'd probably like
17 to. So, I just felt like that part of the report should be
18 strengthened.

19 COMMISSIONER CHECKETT: Well, again, an excellent
20 report and really enjoyed such a thoughtful and ongoing
21 dialogue. You know, I think we started this discussion a
22 long time ago and we're still having it and it's an

1 important one.

2 I do like the historical perspective. I think

3 it's interesting, reflecting, and there are those of us in

4 the room who remember when DSH started and all that type of

5 thing, and they are an interesting relationship. And I

6 think the purpose of DSH has clearly not changed, but so

7 much of the environment has. And for me, personally, I

8 think the ability to kind of ignore the big questions

9 about, you know, how much money are hospitals really

10 getting, how is that being spent, et cetera, I think we

11 just can't really kind of wink, wink or ignore that

12 anymore, and that's actually a philosophical change.

13 And, I think a couple of things, and I guess we

14 could think about whether we need to call it out more

15 strongly or just acknowledge it here, but certainly, the

16 passage of the Affordable Care Act and the fact that so

17 many people -- even though not all 50 states have

18 implemented expansion, we have a lot of people who are

19 insured now and we really do, I think, need to stand back

20 and go, wow, when you've got Medicaid coverage coming in

21 for large groups of people who used to be uninsured, what

22 does that do to DSH and where do we need to really look at

1 that policy? I think that's really important.

2 And, also, we've had a real sea change in terms
3 of, I think, expectations of providers and payers in terms
4 of value-based purchasing. And, you know, everyone needs
5 to be accountable and we're all working towards outcomes,
6 and to continue to just again have these large payments
7 that kind of go into the ether, I think, also doesn't fit.

8 So, those are two things. I don't necessarily
9 know that they need to be written stronger in the report,
10 but I want to make sure they're there, so the ACA and then
11 just, I think, increasing accountability, recognizing the
12 day of just, like, fee-for-service, bill, bill, bill, just
13 is really coming to a much needed end.

14 So, in terms of the recommendation, the only
15 suggestion I would have is just looking at it, is when we
16 say all types, I guess I'm not necessarily certain what
17 that means and it certainly would be something the staff
18 and Anne, we could look at when you really formulate the
19 request. But, I'm just not certain that I'm comfortable
20 with all types.

21 And, finally, just --

22 CHAIR ROWLAND: Or we could explain what "all

1 types" refers to in the rationale for the recommendation.
2 COMMISSIONER CHECKETT: Right. Right. Yeah.
3 That just -- I would feel much better about that, or we
4 will certainly have someone wordsmith it away and it won't
5 end up being "all types."
6 And, finally, just a clarification, and I think,
7 Sheldon, you had asked on IMDs. So, who I think these IMDs
8 are, they're almost all state hospitals, and it's the all
9 state responsibility for the mentally ill, and a lot of
10 states pay DSH funds to those state hospitals and it's a
11 way of, frankly, keeping them open. But, even if you're
12 Medicaid eligible, if you are in that hospital, the state
13 can't claim true Medicaid -- I don't want to say true
14 Medicaid -- fee-for-service Medicaid on that. So, that's
15 my guess. I guess, Chuck, do you want to agree with me on
16 that's who's in those IMDs and that's why they get so much
17 DSH.
18 CHAIR ROWLAND: And perhaps that could be further
19 clarified in the report itself.
20 COMMISSIONER CHECKETT: Right. Right. Because it
21 is certainly the state paying itself, but those are
22 hospitals that are open and serving Medicaid eligibles and

1 a lot of people who are not eligible, adults who are not
2 eligible for Medicaid but who are mentally ill. Thank you.
3 CHAIR ROWLAND: Donna, one of the points that you
4 brought up is one that I think is important for framing
5 this chapter a little more, or this report a little more
6 broadly, is the changing landscape in which we are now
7 operating with regard to the implementation of the
8 Affordable Care Act, the changes in how many states, the
9 policy on DSH, which was premised on the fact that all
10 states would do the expansion and now only half of them
11 have, the shifts toward managed care and the real changes
12 going on in the health care delivery system.
13 And, so, I don't think we need to address how all
14 of these factors are going to shape future DSH policy, but
15 I think it would be useful to set the context. If this is
16 a baseline, we're looking at some pretty technical issues
17 of how to reshape DSH, but we need to also set those in the
18 context of the broader changes going on in the delivery
19 system and in the context of the Affordable Care Act.
20 Okay. Sheldon.
21 COMMISSIONER RETCHIN: I'd like to get back to
22 the issue that was alluded to in the report, but perhaps

1 not underscored, and that's the issue that Mark has brought
2 up about MCOs. So, over 70 percent of beneficiaries are
3 now enrolled in MCOs nationally, and in some states much
4 higher. And, so, DSH is being calculated only on fee-for-
5 service, is that correct, because those data are missing.
6 MR. NELB: Yeah, no. So, on DSH audits, we
7 actually do have managed care information and the costs are
8 sort of summed together for fee-for-service and managed
9 care. But, outside of the DSH audits, for the non-DSH
10 hospitals, we don't have as much detailed information about
11 managed care payments.
12 COMMISSIONER RETCHIN: But the payments
13 themselves are --
14 MR. TEISL: Yeah. So, to be clear, the DSH
15 payments -- the hospital-specific limits are based on
16 Medicaid shortfall for both the fee-for-service and the
17 managed care population, and so the DSH audit data do
18 reflect that.
19 COMMISSIONER RETCHIN: I see. Okay, thanks.
20 CHAIR ROWLAND: Okay. Andy.
21 COMMISSIONER COHEN: Thanks. I don't want to
22 waste time, but I have to also compliment you, because I

1 can't not. It's a great, clear, really well written report,
2 really thorough.
3 I want to second Chuck's suggestion that it will
4 be very -- it will be just a very helpful contribution to
5 explain DSH in context and why it's sort of used the way it
6 is and what it sort of offers to states that other
7 supplemental payments do not.
8 In general, I would say I just have -- I have
9 some sort of thoughts and maybe sort of, like, bordering on
10 sort of concerns about our overall approach, and I think it
11 sort of builds on what Donna was saying, which is that,
12 fundamentally -- or maybe this isn't exactly what Donna was
13 saying, sort of how it feeds into my thinking -- you know,
14 fundamentally, sort of the purpose of DSH that we all sort
15 of intuitively think that we kind of understand, it is to
16 sort of help support hospitals that serve very vulnerable
17 populations, has really been, you know, sort of the program
18 as it exists right now is sort of distorted in a variety of
19 different ways. I mean, there's sort of a total mismatch
20 between the way states have decided to use it and the
21 extent to which they have decided to use it, and, so,
22 there's targeting at the state level which is kind of quite

1 off compared to actual sort of need. And then within the
2 states, the targeting to hospitals is sort of a little off.
3 And, sort of really big picture and conceptually,
4 there's very little match, I think, between what the
5 program looks like today and sort of the intentions,
6 although in -- I mean, you know, your analysis shows that,
7 in bulk, most payments are, in fact, going to deemed
8 hospitals that are serving more uninsured and Medicaid
9 patients, substantially more than their peers. But we
10 don't know that all hospitals that -- you know, there's a
11 mismatch. There's sort of under-match and over-match and
12 sort of all those things --
13 So sort of putting this all together, I do think
14 we can't ignore any more sort of like the big-picture
15 questions here about kind of what is -- what are we
16 targeting. Is it around need and keeping places afloat, or
17 is it about something else, essential services? Is it
18 about whether these hospitals are losing money, or is it
19 just sort of independent of whether they're sort of doing
20 something that is a good -- is it about just like a whole
21 bunch of very sort of fundamental questions?
22 And I have some hesitations about diving deep

1 into sort of more and more data about, like, a very sort of
2 conceptually flawed, although not unimportant, like, very
3 essential to some places' survival for sure. I just have
4 some doubts about whether or not we should first ask for a
5 lot more data and then sort of grapple with the big
6 questions, and I wonder.
7 The data is very important. It's important for a
8 variety of uses. I think I will support the
9 recommendation, but I would be in favor of maybe sort of
10 tweaking the word "all." I'm a lawyer. I can't help it.
11 "All" is just so big, but -- "all," "types."
12 But I do think that it is -- I don't think this
13 is sort of an issue that is sort of soluble by sort of
14 getting super granular at looking at what is. I think we
15 have to sort of grapple with some of the bigger issues
16 about what we think should be ultimately, and I think our
17 data needs could maybe be better targeted if we did it in
18 that order.
19 That said, I understand there are -- we have
20 responsibilities to the Secretary, and I think I will
21 support, if we can maybe address the word "all," the
22 recommendation, but I do have some qualms about going about

1 it this way.

2 CHAIR ROWLAND: All right. So we will have the
3 staff work on clarifying the recommendations, but I am
4 sensing general consensus to go forward with a
5 recommendation in this area and come back at the end of the
6 day to revisit the exact language and to take a vote on it,
7 as we planned in the agenda.

8 What I think has been very useful here is that
9 there's also a lot of additional framing that we want and
10 some other points that we want strengthened, modified, or
11 amplified in the report itself, that we have gotten in
12 comments from the Commissioners here today but as well in
13 other comments from reviewers and others. So that,
14 clearly, Jim and Rob and the staff have a task of really
15 reworking the document itself, and yet I think all of us
16 agree that this is an incredible contribution. It has
17 really gone very far toward meeting a very nebulous request
18 from the Congress to report on all things DSH.

19 I think that, clearly, there's a much longer road
20 to looking at what the policy options may be if you want to
21 use this kind of resource. It goes to the point that we've
22 raised many times about here we have locked in a historical

1 variation in what states can use and not use. That's based
2 not on a, necessarily, rational distribution, but on the
3 way states chose to pursue and implement it. And so I
4 think we really do have an agenda of looking at how you
5 effectively help those institutions that are in need of
6 this.
7 We know that as long as the Affordable Care Act
8 provided for expanded coverage of Medicaid, it did not
9 cover many uninsured low-income people who use many of
10 these facilities, and so part of the charge going forward
11 is to really look at how do you compensate for that as long
12 as we're going to have a low-income insured population.
13 We also know, now that we have the DSH issues
14 between states that expanded and states that didn't and the
15 issue of whether you reward a state that didn't expand
16 because it has higher numbers of uninsured, so you give
17 them more DSH funds, or you in fact say you could have
18 expanded and you wouldn't need all these funds if you had.
19 So we really need to look at some of the broader
20 policy contexts. We can't solve them in this report to
21 Congress, but I think we are providing a very good
22 baseline.

1 So, with that, you've got a lot more work to do,
2 and we're going to revisit some of this, this afternoon, in
3 terms of the data recommendation, and "all" and "types" are
4 two issues we want you to work on, so thank you.
5 And now we're going to turn to a less
6 controversial area. We are going to look at the
7 relationship between CHIP and the exchange coverage for
8 children, and so we're going to call Chris Peterson up to
9 take on this part of our discussion.
10 And thank you, Jim and Rob, again for excellent
11 work, so excellent work. Number two, begin.
12 **### Out-of-Pocket Spending for Children in Separate**
13 **CHIP versus Exchange Coverage**
14 * MR. PETERSON: Thank you, Diane.
15 Before we dive in here, we thought it would be
16 helpful to quickly review our most recent work and
17 discussions in this area. In light of the two-year
18 extension of CHIP passed earlier this year, you have
19 returned to broader questions regarding the future of
20 children's coverage.
21 At the last meeting, we raised questions about
22 the kinds of policies that might ensure adequate coverage

1 and benefits and affordability and raised other issues that
2 might need to be addressed and under what circumstances
3 should CHIP funding be renewed beyond 2017.
4 In September, we had also provided you with
5 information on the characteristics of low- and moderate-
6 income children, and as a follow-up to some questions that
7 had come up, we provided additional information in Tab 1 of
8 your materials, which you probably already saw. And we had
9 also talked about, at the last meeting, coverage issues
10 regarding how many children would become uninsured if
11 separate CHIP ended and what would happen if various
12 policies were put in place to address the resulting
13 uninsurance. Those were just illustrative policies based
14 on some of the five broad approaches we had discussed. So
15 that was then.
16 Today we want to provide you with more detailed
17 information on the dimension of affordability, and this
18 presentation deals with affordability in separate CHIP
19 versus exchange coverage. In the next session, Ben will be
20 discussing children's coverage and employer-sponsored
21 insurance.
22 So we'll begin by talking about the purpose of

1 this analysis driven, of course, by your concerns around
2 the affordability of children's coverage and raised in
3 prior MACPAC reports that compared the affordability of
4 CHIP versus exchange coverage. But those analyses were
5 limited in certain ways. So we contracted with the
6 Actuarial Research Corporation to produce the analyses
7 we're presenting today.
8 And then I'll briefly summarize the data sources
9 and assumptions and then the results that are in the two
10 papers and the numerous tables that you have in your
11 materials, Commissioners.
12 The results are broken into two pieces. The
13 first is, what's the average out-of-pocket health care
14 spending, both cost sharing and premiums, for children in
15 all 36 states with separate CHIP programs, across the
16 entire income spectrum for CHIP-eligible children, and how
17 does that compare to subsidized exchange coverage in those
18 states?
19 The second piece is showing something different,
20 and that is, if children were in exchange coverage rather
21 than separate CHIP, what share would have high out-of-
22 pocket spending? So, for example, CHIP prohibits premiums

1 and cost sharing above 5 percent of income. Well, what
2 share of children would go above 5 percent of income in
3 exchange coverage?
4 So those are the questions we're trying to answer
5 in the second set of results that we'll go over, and then
6 after the results, we'll wrap up with the next steps and
7 open it for your discussion.
8 So our purpose here is to provide more nuanced
9 insights on affordability of coverage. The prior research
10 found that on average, children would face greater cost-
11 sharing in exchange plans compared to separate CHIP. And
12 then the findings in this research are designed to answer
13 some questions with more specificity, again, those two
14 areas that I talked about, the average cost sharing and
15 then the share of children who would exceed various
16 thresholds.
17 It's helpful to keep in mind the context that
18 there is variation in affordability of both separate CHIP
19 and exchange coverage. We know this. We've talked about
20 this with respect to CHIP eligibility and benefits and cost
21 sharing. They vary by state, but they do have to meet
22 federal standards, and in the context of affordability it

1 is that premiums and cost sharing are limited to 5 percent
2 of income.
3 But exchange eligibility, benefits, and cost
4 sharing, they are set in federal statute under broad
5 parameters, but there is actually a lot of variation that
6 we see in these results that exist by not only state, but
7 also the exchange plans within those states in terms of the
8 cost sharing, in particular.
9 And with respect to premiums, you see there that
10 unsubsidized premiums in the second lowest cost silver
11 exchange plans that we looked at ranged across states from
12 $1,200 in Tennessee to $2,700 in New York and Wyoming.
13 This slide is -- if you remember the messy
14 graphical slide that was trying to show variation in the
15 last meeting, this is kind of zooming in the top right-hand
16 corner of that slide, so the point here is looking at just
17 the 6- to 18-year-olds, how eligibility levels differ in
18 the 36 separate CHIP programs we're looking at.
19 So, on the left-hand side, we're looking at North
20 Dakota at 175 percent of poverty, and, Commissioners, we
21 had actually handed out this morning a table that shows you
22 the numbers that are behind this figure. So, in North

1 Dakota, 175 percent of poverty, so at 188 percent of
2 poverty, children of North Dakota, CHIP is not available.
3 They would have to go to exchange or employer-sponsored
4 coverage. And then going all the way up to 400 percent of
5 poverty in New York.
6 And then want to remind you about the federal
7 parameters that exist for exchange cost sharing and
8 premiums by the income levels that we are talking about
9 with respect to CHIP children, and so, to begin with, at
10 133 percent of poverty to 150 percent of poverty, the
11 statute requires that the actuarial value for the plan is
12 at 94 percent. That refers to the percentage of health
13 care spending that is paid for by the plan.
14 Now, for those of you who know the CHIP weeds,
15 you know that actuarial values are sometimes used to talk
16 about benefits. In this context for today's presentation,
17 we're not talking about actuarial value with respect to
18 benefits. It is only about cost sharing. The plan in this
19 example pays 94 percent on average, and on average, the
20 enrollees are paying the other 6 percent. And you see how
21 as income goes up, the actuarial value goes down. And then
22 with premiums, you see that as a percent of family income,

1 what is required out of pocket for the second lowest cost
2 silver exchange plans.
3 So just to give you the key findings before we
4 dive into the details, children losing separate CHIP would
5 face seven times greater out-of-pocket spending. That's
6 referring to both premiums and cost sharing in exchange
7 coverage, and you see the numbers there.
8 The second point is that cost sharing for
9 exchange coverage increases quite substantially as income
10 rises, while CHIP requires little or no cost sharing in
11 most states, CHIP, as you go up the income scale, the
12 increased out-of-pocket spending in CHIP is for premiums
13 generally, not on the cost-sharing side.
14 And then to the second set of results that we
15 wanted to share with you, this is one of the take-home
16 points, is that with exchange coverage, the vast majority
17 of states would have 5 to 7 percent of children in that
18 kind of core income, CHIP income range of 150 to 200
19 percent of poverty, who would have spending above that 5
20 percent of income threshold, a level that's prohibited by
21 CHIP.
22 In terms of the model data, sources, and

1 assumptions, we're using about 4,000 children that are
2 nationally representative of low- and moderate-income
3 children, and then what we do is we take all of these
4 children, essentially, and put them through every separate
5 CHIP program, and then we put them through every second
6 lowest-cost silver plan in that state, in the county that
7 has the most children. And we're doing that because we
8 want to be able to make apples-to-apples comparisons. When
9 we're looking across states and we're looking CHIP versus
10 exchange coverage, we don't want the differences that we
11 see to be a function of who the children are, so that's why
12 we're taking this approach.

13 In some other notes, we're not assuming
14 additional utilization when there is lower cost sharing.
15 We are looking at spending only on standard medical
16 benefits, and as I mentioned, the modeling was done by ARC.

17 So, to talk a little more about the income and
18 premium assumptions, we are using the four income groups
19 that are core notches, if you will, in exchange coverage
20 where the cost-sharing reductions are so much different.
21 And so what we do is we then assume that the children in
22 each of those four income groups have the income that you

1 see here, again, so we can kind of hold the population of
2 children constant.
3 And then, as we've talked about before, the
4 assumptions that you make about the premiums that children
5 are responsible for in exchange coverage can affect the
6 results. Our assumption, which ARC has used in prior work
7 as well, is to assume that the child's share of out-of-
8 pocket exchange premiums is based on the child's share of
9 the total premium.
10 So, limitations, the model does not account for
11 spending on dental and these other issues. For example,
12 and from what we've seen, the exchange coverage, dental
13 coverage for children is about $250 a year. So that would
14 be roughly 10 to 15 percent of total spending. And that's
15 consistent with what I saw in one of Sharon's presentations
16 at NASHP with respect to the percentage of spending for
17 dental. So it's just to keep in mind that the results you
18 are seeing here don't include dental on the QHP side, so
19 that's going to be another difference.
20 And then the model doesn't go down to the
21 molecular level on every single kind of cost-sharing
22 parameter, et cetera.

1 Again, we're looking at the children, if they
2 were enrolled in the exchange coverage, in the second
3 lowest-cost silver plan in the county that has the most
4 kids. So we know that not all kids are going to live in
5 the most populous county, and they're not all going to
6 enroll in the second lowest-cost silver plan. So just some
7 of the up-front limitations.
8 So now we get to the results.
9 Again, to compare separate CHIP to the second
10 lowest-cost silver plan, the actuarial values show that on
11 average, the plan is paying 98 percent of health care
12 spending in CHIP versus 82 percent in the exchange plans.
13 And you see how those dollar amounts turn out with respect
14 to the cost sharing, and then add to that the premiums, and
15 combined is where you get the $148 versus $1,073.
16 Again, a key piece of this is, well, how does
17 this vary by the income groups. A key point is, as you look
18 at the actuarial values, you see that CHIP is in the high
19 90s, kind of across these income categories, whereas the
20 actuarial values fall significantly as you hit these
21 various cost-sharing reduction tiers. Then again, you see
22 how the dollar amounts vary where it's generally in the

1 teens for the dollar amounts of CHIP, whereas you're in the
2 hundreds of dollars when you're talking about exchange
3 coverage. You add to that the premiums, and then combined,
4 you see how much difference there is by these income
5 groups.

6 I want to point out some particular things that
7 might jump out at you. One of them is this 150 to 200
8 percent of poverty range where the actuarial value kind of
9 ticks down in terms of what kids are experiencing in that
10 income range, and then it goes back up. Why might that be
11 the case? And there are two reasons for that. One is
12 Texas, and two is Utah. And we will see shortly the cost
13 sharing that is in Texas, so we'll talk about that more.
14 But above 200 percent of poverty, Utah and Texas don't
15 offer CHIP coverage. They fall out, and then the states
16 that remain have these levels of actuarial values and cost
17 sharing.

18 The other thing that is important to point out is
19 these actuarial values, what the plan pays on average for
20 the kids in our model, and how that compares to the levels
21 that are required under the ACA. So I'm going to move
22 this, these circled numbers here, to the next slide and

1 point out what the plans are paying on average for what we
2 modeled here versus what is required under the ACA. And
3 what I want to point out is when plans are required to set
4 their cost-sharing reductions over the ACA to match a
5 particular actuarial value, they're doing that based on an
6 entire population that includes adults.

7 What we are seeing in these results on the left-
8 hand side of what's circled is the experience of children
9 in those same plans is going to be a little different than
10 for the whole population. And so to illustrate, for these
11 three groups that you see on the screen, you see that the
12 actuarial value for the kids ends up coming out as lower
13 than what is required under exchange plans. And the
14 actuaries tell us, well, this is on average because kids
15 spend less in health care spending than adults, and so
16 children's experience in these plans means the plan isn't
17 paying as much for them on a percentage basis compared to
18 the population overall. But there's a lot of variation in
19 this, and that's why with this other group the trend is the
20 opposite, where the actuarial value turns out to be a
21 little higher than required under the ACA.

22 So now just to walk through a couple state

1 examples to make it more concrete. And we're using Texas
2 and New York because they represent about a third of
3 separate CHIP enrollment, so they're a good example not
4 only in terms of the numbers, but also in terms of the
5 choices that the states have made about where their
6 eligibility levels are and how they do cost sharing and
7 premiums.
8 So for Texas, you see here at the very top row,
9 $19 on average for cost sharing and no premiums. Texas
10 doesn't charge premiums. Then you go up to the next income
11 group, so this is what we had talked about where they
12 charge on average some higher cost sharing, but, again,
13 they don't charge premiums. And then above 200 percent of
14 poverty, CHIP is not offered.
15 Then you go down to the exchange--
16 CHAIR ROWLAND: Above 200 percent of poverty,
17 those kids are already going into the exchange if they have
18 any option.
19 MR. PETERSON: Correct. And you see there on the
20 lower part of the table what those cost sharing and premium
21 levels would be for those children.
22 Now moving to New York, a different situation.

1 New York has chosen, we're not going to charge cost
2 sharing, we're going to charge premiums. And those are
3 just different policy choices, whether it's thinking that
4 we want to have cost sharing that reflects where we want
5 people to pay cost sharing versus, no, we're just going to
6 have premiums. But then premiums raise other policy issues
7 because that becomes kind of a financial barrier to entry
8 to the program, so it's different tradeoffs. And then you
9 see with respect to the exchange coverage at the bottom how
10 those numbers shake out.
11 CHAIR ROWLAND: New York, everyone -- because
12 their income eligibility level is 405 percent of the
13 federal poverty level, no one had to go to the exchange.
14 They're all covered in New York CHIP program.
15 COMMISSIONER RILEY: And could you remind us,
16 Chris, what 250 percent and 400 percent of poverty is?
17 Because this is just the child's share, not the family's
18 share of cost.
19 MR. PETERSON: Say that again?
20 COMMISSIONER RILEY: What is the dollar amount
21 for 250 percent of poverty? What are we -- for household
22 income?

1 MR. PETERSON: I have to do the math in my head.
2 EXECUTIVE DIRECTOR SCHWARTZ: Right here. For a
3 family of three, 250 percent of the poverty line is -- I'm
4 looking at the wrong one -- $50,225. And then for 400
5 percent for that same family of three would be $80,280 --
6 $80,360.
7 COMMISSIONER RILEY: But that cost sharing, of
8 course, is only for the child, not for the families.
9 EXECUTIVE DIRECTOR SCHWARTZ: Right.
10 MR. PETERSON: So now we move on to the second
11 piece, which was really driven by questions that you have
12 asked in prior meetings about, well, what is the share of
13 children whose out-of-pocket spending would exceed various
14 thresholds? And the thresholds that we used were 2 percent
15 of family income, 5 percent of family income, 10 percent of
16 family income, and $1,000, noting that under CHIP you can't
17 exceed 5 percent of income.
18 So the first three thresholds are going to vary
19 by income group and family size, and you see the dollar
20 amounts here on this slide in terms of what those are. And
21 the $1,000 isn't necessarily a policy-relevant number, but
22 it was just in order to keep constant some measure. And

1 you see there on the footnotes what a family of four is at
2 annual income at those particular FPLs.
3 So this is the range of children -- the range of
4 the share of children across states with spending above
5 these thresholds in CHIP versus exchange coverage. So let
6 me walk through a couple examples here.
7 So beginning with 150 to 200 percent of poverty
8 in CHIP, what this tells us is in some states, no kids are
9 having cost sharing of premiums above 2 percent of income.
10 In some states it's 1 percent. In some states it's 2
11 percent. That's pretty much it. Footnote 1 is that Utah
12 is an outlier, and they have 13 percent of their CHIP kids
13 -- children enrolled in CHIP above 2 percent of income in
14 their cost sharing.
15 Contrast that with the experience of what occurs
16 in states in exchange plans, where between a third and 54
17 percent of children would have spending above 2 percent of
18 income.
19 So it seems that on the CHIP side the percentages
20 are really small except for this particular row, and yet
21 even this merits a little more explanation. So there are
22 13 states that offered CHIP above 250 percent of poverty,

1 and, Commissioners, in your materials the numbers I'm
2 walking through are basically in Appendix Table 8. So of
3 those 13 states, 10 have zero or 1 percent of children
4 crossing that 2 percent of income threshold. So not a lot
5 of states. The other three states are Pennsylvania at 3
6 percent, New Jersey at 14 percent, and Missouri at 66
7 percent. So it's still -- even though that 66 kind of jumps
8 out at you, we're talking about just a couple states where
9 this is an issue. But you see the much larger numbers down
10 below for the exchange coverage.
11 And, again, to point out that CHIP prohibits cost
12 sharing and premiums that exceed 5 percent of income and 10
13 percent of income, and yet you see that those levels are
14 hit at every income level for every state with respect to
15 the 5 percent of income for exchange coverage.
16 So to walk through a couple, New York and Texas
17 again, to illustrate, between 133 and 150 percent of
18 poverty, no kids are crossing those thresholds in CHIP.
19 Between 150 and 200 percent of poverty, 2 percent of those
20 kids in Texas would cross that 2 percent of income
21 threshold based on the cost sharing that exists in Texas,
22 and, again, no coverage above 200 percent of poverty in

1 Texas. And you see that the numbers are much larger for
2 exchange coverage and how that varies across those various
3 income thresholds.
4 Then we go to New York, and so in no case would
5 children exceed those 2 percent of income thresholds or any
6 of the others. And that illustrates once more kind of the
7 difference between a state using premiums versus cost
8 sharing because under cost sharing, some children who use a
9 lot of health care spending can end up above a certain
10 threshold. So, again, another tradeoff is that with
11 respect to premiums, all of the kids are kind of facing the
12 same dollar amount, so it's a policy choice there.
13 Then you see again that in New York all -- every
14 one of these income groups, some children would cross that
15 5 percent of income threshold.
16 This slide is adding to the analysis what would
17 happen if we counted the cost sharing and premiums that
18 would exist if we included multiple enrolled children in a
19 family, and essentially the take-home point is the numbers
20 are going to be higher.
21 So the key takeaways are that out-of-pocket
22 spending in the exchange is higher than CHIP in all states.

1 We hope that the additional information that we've provided
2 adds to what has already been out there in the past.
3 Despite the national standards for cost sharing in the
4 exchange, substantial variation by plan and state exists.
5 To Diane's point, the differences in CHIP income
6 eligibility mean that the group of children receiving CHIP
7 cost-sharing protection is going to vary by state. Children
8 are going to be moved into exchange coverage at different
9 points in different states.
10 And then to the second part of our analysis, CHIP
11 prohibits out-of-pocket spending of more than 5 percent of
12 income, but between 1 and 17 percent of children would
13 exceed this threshold in exchange coverage, depending on
14 the state and the plan and family income.
15 CHAIR ROWLAND: Thank you, Chris. So you've
16 again proven that state variations matter, and that as we
17 look at a national policy for CHIP, we really need to take
18 into account the fact that what's going on at the state
19 level varies in terms of how many children are in CHIP
20 versus how many children are already in the income groups
21 that send them to the exchange. And so I think this
22 provides a wealth of data, but it also provides a very good

1 lens to look at if we're trying to make adjustments on a
2 national basis, is there some kind of income eligibility
3 cut that we would want to put in?
4 I would note that in all of the other programs
5 now, because of the way the Affordable Care Act operates,
6 there are uniform income standards, except for the states
7 that haven't expanded for adults, that are being put in
8 place and CHIP does still reflect this wide variation as
9 the table that we put out and where the income eligibility
10 is.
11 And I think that we also know it's a no-brainer
12 that coverage in CHIP was more generous and more -- as Sara
13 Rosenbaum, who is not with us today, pointed out, it was
14 set up to not really be based on fees that are actuarially
15 sound. It was based on how you provide coverage to more
16 children on a layer on top of Medicaid.
17 But I think this does begin to shed light for us
18 on where the income differences and the cost sharing versus
19 premium differences affect the level of out-of-pocket
20 payments for families and the affordability of care.
21 What we are proposing is that this report be part
22 of our ongoing examination of CHIP and that in the March

1 report we would provide this data, but we would set it in a
2 broader context than what's available here. But I'd like
3 to hear your thoughts about what a next step is with this
4 information and what some of your questions may be to Chris
5 about how this is all put together, though I would
6 compliment him on an incredibly lucid presentation of a
7 very complex set of data.

8 COMMISSIONER GABOW: Thanks. This was a great
9 presentation. It was lucid. I have two comments.

10 One is I think in what you handed out to us, the
11 sentence that made me gasp, which I think needs to be
12 pulled forward, was children losing separate CHIP would
13 face seven times greater out-of-pocket spending than
14 exchange coverage. I mean, that's startling, and that
15 doesn't include dental. And as we've been reminded many
16 times in the past, the mouth is a part of the body.

17 The other comment I would make is that in tables
18 like the one that was on page 7 of the slides and is Table
19 3 in what we were given, tables like that that have the
20 percent of poverty and then the separate CHIP cost-sharing
21 premiums total, and the second lowest cost, I think there
22 are two things that would help if they were in the table.

1 One is the federal poverty level, the dollar amount -- this
2 is family of four, I think, in all of these -- because
3 people do forget that.
4 The second thing I'd like to see in those tables
5 is what's the disposable income at that level of FPL. So, I
6 mean, it's relevant if, say, that you're at 250 percent of
7 poverty and the average total cost sharing is $1,500 and
8 your disposable income is $2,000 -- I mean, I don't know
9 what the number is, but it starts to give us the sense of
10 what is realistic in the scheme of families trying to live.
11 So I think that that's important.
12 And I think the other thing which you raised
13 which I think is really good is if you have more children
14 than two, this can add up very quickly, and so I think
15 pointing -- underscoring that -- you have it here, but I
16 think underscoring that is important because those are the
17 families that are probably always hanging on the edge in
18 terms of food insecurity, housing insecurity, and a variety
19 of other issues. But thank you for the clarity of the
20 presentation and the clarity of the report.
21 COMMISSIONER CARTE: Chris, thank you, as always,
22 for this excellent work on the CHIP issues, and I think

1 it's ironic that we're looking at this data this week when
2 Georgetown Center on Children and Families has just
3 released data showing the progress that states have made on
4 decreasing the rates of uninsurance for children while this
5 data should cause us grave concern, because I think what we
6 see is a picture of likely continuing erosion of children's
7 coverage going forward into the future just because of the
8 factors that Patty and I'm sure the rest of you see when
9 you look at the data.
10 So my question for you is pretty simple, and
11 given what Diane was just saying about the March report, I
12 assume -- or you could tell me when we can track and update
13 this data as we go forward? I mean, I think it's important
14 for the Commission to be able to continue to look at the
15 impact of the continuing premium increases and cost
16 sharing. In my own state, they just announced that the
17 premium increases for the coming marketplace are well in
18 advance of the national average.
19 And the other point I'd just make for the
20 Commission is that I think that state representatives as
21 well as members of Congress may be operating under the
22 assumption that, should CHIP go away, it's just fine

1 because we've got the marketplace out there. I think we're
2 seeing a pretty drastic picture here of what could be done
3 for the families in CHIP, and it makes me fearful that all
4 the games that CHIP has brought about could be easily
5 washed away.
6 MR. PETERSON: So as we think about putting this
7 in the March report, we will have to assess the extent to
8 which we rely on 2016 exchange information and CHIP
9 information versus the 2015 exchange information we have in
10 that report. So we will take a look at that. But the next
11 piece that we have coming to you based on the current data,
12 the third piece of this analysis, will be to look at among
13 those children who have crossed these thresholds that we
14 talked about in the exchange plan, so above 5 percent of
15 income or 10 percent, what are the characteristics of those
16 children? So that is going to be the next piece that we
17 might be bringing to you in December.
18 COMMISSIONER CARTE: Thank you.
19 COMMISSIONER SZILAGYI: A couple of comments to
20 add. I think you were an educator or a teacher in your
21 previous life because you explain things extremely well,
22 and it's a great report. Not something to put into the

1 report but something in terms of context that children's
2 health care utilization is very elastic and very related to
3 cost sharing. This goes all the way back to the RAND Health
4 Insurance experiments, and numerous studies have shown
5 this. So that increased cost sharing, even at tiny levels,
6 will result in significant reduction in use of not so much
7 hospital care or even ED care, but outpatient care,
8 preventive care, even immunizations, and lots of things
9 that people think are important for kids.
10 So not for the report, but in terms of context, I
11 think it's really clear from prior data that increased cost
12 sharing will result in less preventive care and less
13 quality of care for --
14 CHAIR ROWLAND: But, Peter, we do have to be
15 careful there about which services we're talking about
16 since the preventive services are exempted from cost
17 sharing.
18 COMMISSIONER SZILAGYI: Right. But there's even
19 data in the literature that even though immunizations, for
20 example, are exempted from cost sharing, because of other
21 costs like going to the doctor and sort of other costs,
22 providing health insurance increases immunization rates

1 even though the patients don't have to pay for the
2 immunizations.
3 CHAIR ROWLAND: It's just, I think, our point
4 would be that we're not -- in looking at coverage in the
5 exchange, we at least should recognize that as part of the
6 exchange coverage.
7 COMMISSIONER SZILAGYI: Right, right.
8 A question I had is -- you used the second lowest
9 silver plan. Do we have information about where children
10 are likely to go? You know, what's the pattern of
11 switching if CHIP goes away? And what would happen if you
12 would use other options?
13 MR. PETERSON: I am trying to think because my
14 colleague, Veronica, had kind of looked at this issue.
15 EXECUTIVE DIRECTOR SCHWARTZ: Basically, we have
16 very little -- we have very little information about kids
17 in the exchange, much less than we would like to know --
18 you know, you can think of any question; we don't really
19 know it. And we also -- that gives us very little basis to
20 sort of say take another group and figure out what choices
21 they would be making based on what these kids' choices are.
22 So we just don't really have enough experience at this

1 point or enough information about what's happening to the
2 kids who are in the exchange to be able to talk about that.
3 Now, that's something we could speculate and
4 think about some different scenarios, but there's not much
5 right now to guide your decision-making in that respect.
6 COMMISSIONER SZILAGYI: And a third quick point
7 is I would -- in the future, I would think about looking at
8 special needs kids or kids with chronic diseases as a
9 subgroup, if you can.
10 MR. PETERSON: So that's actually the purpose of
11 the third part of the analysis is to flag -- okay. So the
12 children who are across these thresholds in exchange
13 coverage, if they move from CHIP to exchange, what do they
14 have? What are the conditions that they have? And so
15 we're looking in particular at mental health, asthma, COPD,
16 whether they had an inpatient stay. What happens in these
17 kids' lives? Is it a chronic condition for many of them?
18 Is it acute? What mix? So we hope to bring that to you in
19 the December meeting.
20 COMMISSIONER MILLIGAN: Great work, Chris, and it
21 looks like you're the master's degree PowerPoint person of
22 all of us.

1 There's a few points I wanted to make. I
2 apologize in advance if it's not -- if I'm sort of working
3 through this as I talk about it. The first one is the
4 cleanest, actually, which is I think this really justifies
5 MACPAC's previous recommendations about the need to -- in
6 the interest of children's coverage and access to insurance
7 and access to care, that the gap between CHIP and the
8 Qualified Health Plans with various federal subsidies is
9 real, and that those kinds of things need to be addressed
10 in the context of discussions around CHIP get to sunsetting
11 over time.
12 And so I do think that MACPAC's previous
13 recommendations about some conditions that would need to be
14 essentially addressed in QHPs and otherwise, as a part of
15 the discussion of CHIP getting -- I think those -- I think
16 your work confirms the importance of that way of thinking
17 about these, the relationships between these programs.
18 There's a couple of other points that I want to
19 make that I'm not quite sure whether and how to address for
20 you all, but I just want to make some sort of policy
21 observations. One is that when I look at the Texas data on
22 the slide, I would be very discouraged if I'm a parent in

1 Texas about getting a pay raise that would take me from 198
2 percent of poverty to 202 percent of poverty because that's
3 a pretty significant cliff in terms of keeping my child
4 covered because I'm getting out of the CHIP program and
5 into the QHP. And that change in out-of-pocket would
6 overwhelm whatever pay increase drove that change in the
7 poverty level of that household.
8 And so the policy point I want to make about this
9 is there's a lot of areas where federal policy tries to
10 address incentives to work and incentives to earn more
11 money and tries to address disincentives to do that. And I
12 think that one of the policy observations is we've got some
13 disincentives in the data you shared about moving into a
14 higher income level, but diminishing the families available
15 to disposable income, and so I do want to make that policy
16 observation. I would decline a cost-of-living increase
17 that would take me out of that at the crux of that. So I
18 think to the extent that this affects decisions about
19 moving up the income ladder of a household, I just want to
20 make that observation.
21 The second observation I want to make is this is
22 another example like we talked about with DSH where legacy

1 history is ongoing in current policy discussions, and I
2 want to sort of elaborate on this a little bit.
3 I was the Medicaid director in New Mexico when
4 CHIP came into existence. New Mexico had recently raised
5 Medicaid eligibility levels for children to 185 percent of
6 poverty in 1996 through age 18. CHIP comes along, and the
7 law says you can't use CHIP to swap out Medicaid funding.
8 You can only use CHIP to go up the next 50 points of the
9 federal poverty level, and so in New Mexico, that's kind
10 of, more or less, what happened, is the CHIP program was
11 from 185 to 235, more or less.
12 In other states that had not raised Medicaid
13 eligibility levels for children when CHIP comes along, then
14 you can use CHIP at 150 percent of poverty, 175 percent of
15 poverty. And so we've got again sort of a distributional
16 issue that's based on history that continues to play out in
17 current discussions.
18 And so the policy point I want to make is -- and
19 to my fellow commissioners as well, as we discussed with
20 DSH where there is kind of an allocational, distributional
21 inequity around the country, that maybe could be remediated
22 in terms of how funds, DSH funds, are targeted in the

1 future to where they're needed or not. CHIP funding is the
2 same conversation. The federal CHIP funding, presumably,
3 could be used then to address deficiencies with out-of-
4 pocket and qualified health plans below 250 percent of
5 poverty that would have more of a distributional equity
6 around the country, although there would be winners and
7 losers among children and states. And by that, it would
8 be, in some ways, punishing the states that raised
9 eligibility early and now have CHIP up to 400 percent of
10 poverty or New Mexico where raise Medicaid early, and now
11 CHIP is helping higher income kids. But if you take those
12 federal funds and then kind of fix -- fix, quote/unquote --
13 fix the out-of-pocket problems with qualified health plans
14 at those income levels, up to 250 percent of poverty, it's
15 a redistributional conversation we're having, much like the
16 DSH was a redistributional conversation we're having. And
17 I want to be very explicit about that at a policy
18 conversation level.
19 And the last point I want to make -- and again,
20 I'm going to try to tie a couple of things together with
21 DSH. I forget now which state. I think it was -- was it
22 New York, where it was -- it was really more on the premium

1 side for CHIP? Okay. The effect of that is, in many ways
2 -- and the literature supports this -- is if you have
3 premiums, the take-up is typically less of the healthier
4 kids because there's an immediate cost for the premium, and
5 there isn't as much of an immediate benefit. And so there
6 isn't as much take-up.

7 And the effect of that might be you have more
8 uninsured kids or families that just choose not to do the
9 take-up of the CHIP premium, and the effect of that might
10 be -- those are a lot more of the uncompensated care, if in
11 fact there's an accident or trauma or kid gets injured and
12 then needs to seek medical care. And so that is a
13 different way of -- then it becomes uncompensated care.
14 It's DSH. It's tax exemptions, all those things. And so
15 the point I'm trying to make is how a state chooses to
16 distribute its costs to the families as between copayments
17 and deductibles and the like versus premiums has effects on
18 these other policies that we're talking about.

19 I know that I'm sort of maybe blending a lot of
20 things in my comments, but I'm just trying to tie some of
21 these policy discussions we're having together, so thank
22 you.

1 MR. PETERSON: The only thing that I would add to
2 your point is that I think the states that charge those
3 premiums would say, "We do it at higher income levels, and
4 we do it in order to prevent some crowd-out." So, as you
5 get higher up the income scale and these kids are offered
6 employer-sponsored coverage, this is one of the ways that
7 we can make that choice a little more equitable.
8 COMMISSIONER COHEN: Chuck said it all
9 beautifully, so I'm going to pass mainly about the point
10 that you're sort of looking at the cost sharing today as it
11 is, but that there is sort of -- and making a really
12 important point about the difference between the two
13 programs. But that neither -- the level of cost sharing is
14 sort of not inherent in CHIP or really on the exchange, so
15 you can look at the issues as amenable to change.
16 COMMISSIONER ROGERS: I just want to make a
17 comment and add to what Chuck was saying in terms of
18 federal policy and increase in salaries and people looking
19 at that. Coming from Texas, I could reassure you that
20 people are going to take that increase in salary because
21 they're thinking about the income that's coming into the
22 house, and so what ends up happening is that they are not

1 looking at the effects in terms of health care for their
2 children, what's going to happen with that.
3 And so going along with what Peter was saying is
4 that what's going to end up happening is that we're going
5 to have an over-usage of the ER because those kids are
6 going to get sick. If they're not being taken care,
7 they're going to get sick, and they're going to end up
8 going to the ER because they don't have coverage.
9 COMMISSIONER RILEY: Again, that was a terrific
10 job.
11 As we play out the policy options per our
12 recommendation, it seems to me we might want to -- I'd
13 really like to play out this notion of what would happen if
14 the CHIP dollars would converted into APTC supplements or
15 some kind of additional tax credits.
16 I think what would strengthen our report is to
17 remind everybody that CHIP is a block grant, and so if we
18 can reasonably protect children in an exchange environment
19 with a tax credit, we've in fact enabled children to be
20 covered up -- any cliffs are taken care of. They remain
21 covered, and we don't have to deal with the block grant
22 issues of limits.

1 CHAIR ROWLAND: And, Chris, obviously, what we
2 have here is really good information to use as we go
3 forward in our analysis. I think we have raised a lot of
4 the kind of points that, as we try to frame this as a
5 chapter to put information out in our March report, need to
6 be recognized and taken into account as we discuss the
7 data.
8 I'm glad that you're continuing the analysis, and
9 we'll come back, really, I think, very importantly with
10 some of the information on the characteristics of the
11 children who exceed those out-of-pocket limits.
12 But I also think one of the real contributions
13 here is that you really have shown how it really does vary
14 so much in all the backup tables by state and by the state
15 choices and policies there, and I think we do need to look
16 at the interaction of where the Medicaid upper income
17 eligibility level is versus for CHIP, building on Chuck's
18 earlier comment, but also because if CHIP went away, the
19 kids in Medicaid would have some of the protections that
20 they don't have today.
21 But we'll continue. This is not the end, but
22 just the very beginning of a very exhaustive examination

1 that we want to undertake about children's coverage broadly
2 and about the levels of protection they have.
3 And I would say that this is a good transition to
4 Ben Finder in our next discussion about coverage in the
5 employer sector because I think the other thing we need to
6 keep in mind as we go forward is that the whole nature of
7 health insurance coverage not just in the exchanges, but
8 especially in the employer-based system, is changing very
9 rapidly, too, from having much more of an up-front
10 deductible, much more skin in the game. And so we need to
11 think about our recommendations and our coverage in the
12 context of the broader health care system, not just of the
13 limited lens through which we see CHIP and Medicaid.
14 So, with that, we'll turn to Ben at Tab 4.
15 **### Trends in Employer-Sponsored Insurance Related to**
16 **Children's Coverage**
17 * MR. FINDER: Thanks, Diane. That was a good
18 spoiler for my presentation a little bit. There are more
19 deductibles; premiums are higher.
20 As Chris noted earlier, the Commission has
21 returned to the broader questions on the future of
22 children's coverage in light of the two-year extension of

1 CHIP funding. At last month's meeting, several
2 commissioners expressed interest in better understanding
3 children's experience with employer-sponsored insurance.
4 And although employer-sponsored insurance is outside
5 MACPAC's statutory mandate, this information would better
6 inform our conversation on the future of children's
7 coverage. So, to that end, this presentation today is
8 intended to provide a snapshot of key trends in employer-
9 sponsored insurance as they relate to children's coverage.
10 First, a little context for our conversation.
11 Employer-sponsored insurance is the most common form of
12 health insurance in the United States, although public
13 coverage is more common for children and families with
14 incomes below 200 percent of the federal poverty level.
15 And as we noted last month, if separate CHIP
16 funding ended in 2016, about one-third of children
17 previously enrolled in CHIP are projected to enroll in
18 employer-sponsored insurance coverage.
19 It's important to recall the evolution of
20 employer-sponsored insurance. Although it existed in
21 various forms before, it emerged during World War II when
22 the War Labor Board exempted it from wage and price

1 controls. This allowed employers to use health insurance
2 as a fringe benefit to compete for workers.
3 Federal policy exempts employer- and employee-
4 paid premiums for health insurance from income taxes. CBO
5 estimates the tax exclusion to be worth $250 billion
6 annually.
7 And there are a few other federal requirements
8 for employer-sponsored insurance. It must provide at least
9 60 percent actuarial value, including hospital and
10 physician services, to meet minimum essential coverage
11 standards and requirements.
12 Federal law limits out-of-pocket maximums for
13 employees and workers covered by employer-sponsored
14 insurance, and employers are not required to offer
15 coverage, but could face financial penalties in certain
16 circumstances due to the employer mandate.
17 So there are six points that we'll cover during
18 this presentation. The first is that children in low- to
19 moderate-income families are less likely to have access to
20 employer-sponsored insurance.
21 Secondly, the likelihood that a firm offers
22 health insurance to its employees varies by a number of

1 factors. Large firms are more likely to offer coverage,
2 and among firms that offer coverage to their employees,
3 most offer dependent coverage.
4 Even if employees are offered coverage, low-
5 income families may consider it unaffordable, and I will
6 present some information later about the average cost of
7 premiums, including worker contributions to premiums.
8 In addition to premiums, families are likely to
9 face deductibles and other cost-sharing requirements.
10 And finally, most employer-sponsored insurance
11 plans cover inpatient and outpatient services, physician
12 services, and prescription drugs.
13 So before I begin with the meat of the
14 presentation, there's one last point that I'd like to make.
15 Employer-sponsored insurance varies from employer to
16 employer. That means that the coverage a child has,
17 including premiums, cost-sharing requirements, and benefits
18 will be different, depending on where their parents work.
19 So now on to access. Children's access to job-
20 based health insurance varies significantly by income.
21 About one in four children in families with incomes at or
22 below 138 percent of the federal poverty level have access

1 to employer-sponsored insurance coverage, and you can see
2 that family income increases -- as family income increases,
3 so does the likelihood of children having a parent being
4 offered job-based health insurance.

5 As I mentioned earlier, the likelihood that a
6 firm offers health benefits varies by a number of different
7 characteristics. It's driven largely by firm size. You
8 can see that large firms -- those with 200 or more
9 employees -- are more likely to offer health insurance than
10 small firms, those with between 3 and 199 employees. It's
11 worth noting that low-income parents are more likely to
12 work in small firms than in large firms.

13 Firms with a high proportion of low-wage workers
14 are less likely to offer health insurance to their
15 employees than firms with a low proportion of low-wage
16 workers.

17 And few firms offer health coverage to part-time
18 employees and temporary workers.

19 There are a few other factors that are not on
20 this slide, one of them being industry, where retail and
21 agriculture firms are the least likely to offer health
22 insurance, and at the same time, parents with incomes at or

1 below 200 percent of the federal poverty level are more
2 likely to work in agriculture than all other workers.
3 And overall, the percent of firms offering
4 coverage has declined over the last 15 years.
5 The cost of coverage is another key factor in
6 whether families will take up employer-sponsored insurance.
7 Premiums for family coverage have increased steadily since
8 1999. During this time, growth in employer-sponsored
9 insurance premiums and worker contributions to those
10 premiums have outpaced inflation and workers' earnings.
11 There's considerable variation around this
12 average as well. For example, about 18 percent of workers
13 face total premiums less than 80 percent of this average,
14 so those are premiums that are less than about $14,000.
15 On the other hand, about 20 percent of workers
16 are in firms that face premiums greater than 120 percent of
17 these averages. Those are premiums that are greater than
18 about $21,000.
19 Total premiums for family coverage and worker
20 contribution to premiums vary by certain firm
21 characteristics like firm size, whether a firm has union
22 employees, whether a firm is self-funded or fully insured,

1 and by plan type. For example, PPO plans have the highest
2 average annual premium, while workers in high-deductible
3 health plans with a savings options have the lowest.
4 In the next slide, we will focus more on the
5 variation of worker contributions, but before we move on, I
6 want to call attention to the lower bar, the worker
7 contribution to the premiums. You can see the amount that
8 workers contribute toward the cost of family coverage has
9 increased steadily since 1999. At the same time, the share
10 of the premium that workers pay has been relatively stable,
11 especially since 2010.
12 The share of family coverage paid by workers has
13 mostly been between 26 and 29 percent of the total premium
14 during this time period.
15 And of course, there's significant variation in
16 worker contributions to the total cost of family coverage.
17 For example, 6 percent of workers are in firms that pay the
18 full cost of family coverage. On the other hand, 15
19 percent of covered workers are in firms that require
20 employees to pay more than 50 percent of the annual
21 premium.
22 Workers in large firms pay less than workers in

1 small firms for family coverage, and as I mentioned
2 earlier, low-income parents are more likely to work in
3 small firms than large firms. Workers in firms with many
4 low-wage workers contribute more than workers in firms with
5 fewer low-wage workers, and workers in plans that are fully
6 insured pay more for family coverage than workers in self-
7 funded plans.
8 More people have a deductible, and it's grown
9 such that most employees are enrolled in a plan with a
10 deductible. Eighty-four percent of private-sector
11 employees were enrolled in a plan with a deductible for
12 family coverage in 2014, and the amount of that deductible
13 has grown too.
14 The likelihood of having a deductible varies by
15 plan type, and by plan type, I mean things like HMO, PPO,
16 or high-deductible health plan. But the likelihood of
17 having a deductible does not vary by firm size.
18 There is some variation in the structure of
19 family deductibles too. Typically, firms require families
20 -- the entire family meets an aggregate annual deductible
21 before the plan will cover certain costs. Less common, some
22 plans require that each member of a family meet a separate

1 per-person deductible, and here I have chosen to focus on
2 the aggregate family deductibles.
3 The amount of the deductible ranged from just
4 over $1,500 to just under $5,300 in 2015, depending on the
5 plan type and firm size. For example, high-deductible
6 health plans generally have a higher deductible than HMO
7 plans.
8 And there's additional cost sharing required for
9 certain services like physician's office visits and
10 prescription drugs.
11 The March 2015 report compared benefits among
12 different sources of coverage. In that report, we found
13 that most employer-sponsored insurance plans cover
14 inpatient and outpatient services, physician services, and
15 prescription drugs. For other services, we found that
16 coverage varies. Many firms cover services such as
17 physical therapy, occupational therapy, speech therapy, and
18 autism services. More than half of all plans do not
19 include pediatric dental coverage, and of the employers
20 that offer separate dental coverage, many require an
21 additional premium.
22 Most benefit mandates are issued at the state

1 level, although some mandates may not apply to self-funded
2 plans.
3 And for your reference, about 63 percent of
4 covered workers were enrolled in partially or completely
5 self-funded plans in 2015.
6 So that was a very quick snapshot of the key
7 trends in ESI for you or draw upon and pull into our
8 conversation on the future of children's coverage as we
9 continue along. I look forward to your questions and
10 comments.
11 CHAIR ROWLAND: Okay. Patty?
12 COMMISSIONER GABOW: Thank you.
13 There's a lot of data here, and so trying to meld
14 it into a conclusion, I think, as we go forward, is going
15 to be really important. So I took a shot at it, and I
16 wondered if you would agree or the other Commissioners
17 would agree with this, but it sort of flows like this.
18 Given which firms offer health coverage to families, the
19 plans that they offer and the premiums and deductibles of
20 those plans suggest that, yes, it would not likely be a
21 robust alternative to CHIP for low-income families. That's
22 what all these data points seem to funnel down to, to me.

1 Maybe that's not -- maybe that's an overly broad statement,
2 but I do think it's important, as we try to put employer-
3 sponsored coverage into this puzzle of CHIP, even though I
4 know it's not our mandate to look at it, as I -- I think if
5 we really think that, it's unlikely to be a robust
6 replacement to CHIP for low-income families. That's an
7 important sort of pillar for us to use as we go forward.
8 If that's not the appropriate summary of data,
9 then I think --
10 CHAIR ROWLAND: Well, I think it's important to
11 remember that CHIP was created because ESI was not working
12 for low-income, moderate-income children, so it was an
13 attempt to help provide working families who were low
14 income and in these places which didn't offer coverage or
15 where coverage was unaffordable to be able to provide
16 coverage for their children.
17 COMMISSIONER GABOW: And it's even gotten less
18 likely.
19 CHAIR ROWLAND: And it's gotten worse since 1997.
20 COMMISSIONER GABOW: So, to put it into context,
21 that it was established because of this gap and things have
22 gotten further down the lane, I think it's important to say

1 we don't see this now suddenly as an alternative.

2 CHAIR ROWLAND: But I also think that it's

3 important just maybe to get the universe numbers out to

4 really look at, by income, how many children are in

5 Medicaid, in CHIP, which I know is hard to sort out because

6 those data are not really clear, and have employer-based

7 coverage versus being uninsured, so that you can really see

8 the extent to which children in lower incomes are already

9 in the employer-based system.

10 Other comments?

11 EXECUTIVE DIRECTOR SCHWARTZ: I was just going to

12 add to that. There is attention also, though, in the CHIP

13 design, and you see it differently in different states

14 about concerns about crowd-out, and that's why premiums

15 exist more in some states than in others and also why

16 waiting periods existed as well. And that's not to make a

17 statement about -- you know, to counter yours, but there's

18 this sort of inherent piece from a public policy

19 perspective, the desirability of one form of coverage

20 versus the other, depending upon what your goal is.

21 CHAIR ROWLAND: Sharon?

22 COMMISSIONER CARTE: Ben, I could have missed it

1 in a footnote or something, but for ESI, does that include
2 employers like state governments or other public plans?
3 And thank you for this information because, in
4 the same sense, even though Patty was saying it might be
5 overly broad, premiums and cost-sharing increases impacts
6 low-income families, and this is also part of that picture.
7 MR. FINDER: Generally, it does include public --
8 the state and local governments, except for where I've
9 noted that it's private-sector employees. So the one
10 statistic, I think, that I mentioned was 84 percent of
11 families enrolled in private-sector coverage have a
12 deductible. That one does not include public-sector
13 employees.
14 CHAIR ROWLAND: Any other questions?
15 Chuck.
16 COMMISSIONER MILLIGAN: Just a comment, mainly.
17 As MACPAC staff models what would happen if CHIP goes away
18 in some of the data we saw last year, I just want to
19 emphasize then that a lot of the work that you're showing
20 is how rapidly ESI is changing, and so this is going to be
21 an example where it's going to be very hard to predict
22 where CHIP children would end up because ESI is not static

1 right now in terms of what employers are doing to try to
2 manage their costs and then move more and more people into
3 high-deductible plans.
4 CHAIR ROWLAND: Other comments?
5 [No response.]
6 CHAIR ROWLAND: Okay. Thank you, Ben.
7 And I think this is some information that we were
8 thinking would be potentially useful to put out maybe as an
9 issue brief just to have as part of our Website, but to
10 continue to at least keep track of what's going on in the
11 ESI world, so that we are always operating by putting
12 Medicaid and CHIP in the broadest context. Thank you.
13 At this point, we will then ask for anyone in the
14 public audience who wants to offer a comment to us about
15 any of the issues this morning to please come forward,
16 identify yourself, and your comments will be entered into
17 the record.
18 **### Public Comment**
19 * MS. GONTSCHAROW: Good morning. My name is Zina
20 Gontscharow. I'm with America's Essential Hospitals, and
21 we thank the Commission for the opportunity to provide
22 comments this morning.

1 America's Essential Hospitals is the leading
2 association and champion for hospitals and health systems
3 dedicated to high-quality care for all, including the most
4 vulnerable. Our more-than-275 member hospitals provide a
5 disproportionate share of the nation's uncompensated care
6 and devote roughly half of their inpatient and outpatient
7 care to Medicaid or uninsured patients. Our members
8 provide this care while operating on margins substantially
9 lower than the rest of the hospital industry, an aggregate
10 operating margin of negative 3.2 percent compared with
11 positive 5.7 percent for all hospitals nationally.
12 We thank the Commission and its staff for its
13 hard work on the Medicaid DSH payment study and look
14 forward to its release. As this study is finalized,
15 America's Essential Hospital is encouraged by the
16 Commission's recommendations around the data options needed
17 to ensure the accurate insight into the Medicaid DSH
18 program.
19 In light of the current data limitations, the
20 association urges the Commission to clearly note the impact
21 of the data limitations in the study to ensure that
22 incorrect assumptions or conclusions are not drawn about

1 the Medicaid DSH program and the providers that rely on
2 this vital funding stream.
3 Further, as the study calls for an identification
4 of hospitals with high levels of uncompensated care that
5 also provide access to essential community services, we
6 urge the Commission to focus on the mission-driven
7 hospitals that are currently serving this role in their
8 communities. These are hospitals that are committed to
9 caring for the most vulnerable, training the next
10 generation of health care leaders, providing comprehensive
11 coordinated care, providing specialized life-saving
12 services, and advancing public health.
13 We appreciate the opportunity to provide these
14 comments and look forward to continue collaboration. Thank
15 you.
16 CHAIR ROWLAND: Thank you for your comments, and
17 also, the Commission members have received the letter from
18 America's Essential Hospitals, and we will enter that in
19 the record as well. Thank you.
20 Any other comments?
21 [No response.]
22 CHAIR ROWLAND: If not, we will adjourn for a

1 lunch break and reconvene at 1:45 -- 1:15. I'm sorry. I
2 wanted a long lunch. 1:15. Thank you.
3 * [Whereupon, at 11:43 a.m., the meeting was
4 recessed, to reconvene at 1:15 p.m. this same day.]
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1 AFTERNOON SESSION

2 [1:24 p.m.]

3 CHAIR ROWLAND: We're going to reconvene now to
4 really look at one of the challenging issues in long-term
5 services and supports, both for Medicaid as well as for
6 other programs that provide some coverage for long-term
7 services and supports, and that's the need for functional
8 assessment tools to determine both who's eligible for
9 services and to help with care planning. And Kristal
10 Vardaman is going to share with us the inventory and the
11 wide range of measures now available so that we can begin
12 to focus on what would be a required or a good core set of
13 measures. This really does grow out of the work of the
14 Long-Term Care Commission where one of their major
15 recommendations was the need for some standardization in
16 how we measure the need for services for this population.
17 So, Kristal, I know you have got a really long
18 report, and you are going to shorten it to some highlights
19 for us.
20 **### Functional Assessment Tools for Medicaid Long-**
21 **Term Services and Supports Eligibility and Care Planning**
22 * MS. VARDAMAN: Right. Thank you. Good

1 afternoon, Commissioners. I'm glad to have a chance to
2 discuss with you the results of some work we conducted on
3 the functional assessments for LTSS.
4 First I'll start off with some background on the
5 purpose, use, and design of these tools. Next I'll talk
6 about the results of a comprehensive inventory of tools
7 currently in use by states that we had a contractor
8 conduct. And then I'll end with some policy questions and
9 next steps.
10 As you're aware, eligibility for long-term
11 services and supports in Medicaid is determined by two
12 different criteria: first, by financial criteria; and
13 then, second, by functional criteria. So the functional
14 assessment tools are used by states to get information on
15 an applicant's health status and needs to determine their
16 functional eligibility for Medicaid-covered LTSS. States
17 do vary in the level of impairment that's needed to qualify
18 for different programs that they offer in terms of LTSS
19 benefits, and so this is how they assess applicants' needs
20 for that section of eligibility.
21 These tools are also often used to formulate care
22 plans. They collect a lot of information on clinical needs

1 and impairments, which we'll go into a little bit more
2 later, and thus are a rich set of information that can be
3 used to develop care plans for Medicaid beneficiaries.
4 There are limited federal guidance on the
5 requirements for these assessments, which has led to wide
6 state variation, which we found, and the inventory we'll
7 discuss a bit later.
8 In terms of how states come about the decisions
9 to use one tool or another, there are different approaches
10 that states can take. They can use a tool that's been
11 developed by another state or by a vendor, either without
12 modification or with some modification, or they can create
13 their own tool. And there is not a lot of information on
14 why states choose one approach over another, but some of
15 the literature suggests that their decisions are likely
16 influenced by factors like the time frame it takes to
17 develop a tool or to implement a tool, the cost of either
18 of those options, and also stakeholder input.
19 There have been some concerns about variation and
20 the lack of transparency that makes it difficult to
21 evaluate how well programs are meeting beneficiaries' LTSS
22 needs, and as mentioned, the 2013 Commission on Long-Term

1 Care, among others, has recommended a more standardized
2 approach to assessment across the states.
3 In the June 2014 report chapter on Medicaid's
4 role in LTSS, MACPAC also raised concerns about the lack of
5 standardization, and the Commission noted it was an area
6 they were interested in, that you all were interested in
7 monitoring over the future.
8 So in order to better understand current state
9 practices, we contracted with NORC at the University of
10 Chicago to compile a comprehensive, nationwide inventory of
11 functional assessment tools, and I'd just like to thank
12 NORC for their work in this area. As you will see in a
13 moment, it was certainly a large undertaking.
14 There are a number of research questions that we
15 had in doing this work. Among them were how many states
16 are using multiple tools; what established tools have been
17 used most often, either modified or unmodified; to what
18 extent are states using the same tool for eligibility
19 determination and care planning; and also to what extent
20 are states tying these results to other information,
21 including the rate-setting process.
22 So to undertake this work, NORC collected copies

1 of the functional assessment tools, looking at state
2 Medicaid websites, sister agencies, whatever documentation,
3 and information from vendors. There were some states that
4 we followed up with because the information was not
5 publicly available. And NORC reviewed the tools and
6 developed a template describing the characteristics of the
7 individual tools as well as summary tables. So what was in
8 your material was the really sort of very high level
9 summary table. The full deliverable contains a more
10 comprehensive table that compares a few dozen
11 characteristics across all of the tools, as well as backing
12 tables that describe each individual tool in more detail.
13 So as I said, it was a large undertaking, and
14 they found that there were actually 124 distinct functional
15 assessment tools currently in use. So there are some tools
16 that are usually developed by a vendor, like the Supports
17 Intensity Scale that may be in use by multiple states. But
18 in this 124, that is only counted one time, even if it is
19 used across multiple states.
20 So, on average, states are using three functional
21 assessment tools each, and just to explain that a little
22 bit further, there may be a lot of reasons why states are

1 using different tools or they've chosen different
2 configurations on how they're going to use the tools. For
3 example, a state may have one tool for individuals with
4 physical disabilities and another tool for individuals with
5 intellectual developmental disabilities. They may have
6 tools that are different depending on whether it's a state
7 plan or a waiver service. They may have tools that are
8 different across different types of waiver services, or
9 some combination of those factors. So we saw really states
10 that sort of ran the gamut in that respect.

11 So functional assessments that are in use
12 currently, all those 124, really varied widely on all the
13 different dimensions that we examined, and most states are
14 using tools that they developed themselves rather than
15 those that were developed independently by vendors or
16 another entity.

17 In terms of what domains were assessed, again,
18 the main function of these tools is generally to assess
19 eligibility and level of impairment. Thus, functional
20 limitations were the most commonly included domain. The
21 other most common domains included clinical needs or health
22 status and behavioral and cognitive status. In addition,

1 many of the tools asked about the physical environment a
2 person lived in, their psychosocial needs, or other issues,
3 which could often give a fuller picture of some of their
4 needs.

5 In terms of who conducts the assessment, this is
6 an area that was of interest because there have been
7 concerns that potential conflicts of interest could arise
8 if providers were responsible for assessments. What we
9 found were most states are using state or local employees
10 or a state contractor to conduct these assessments. And
11 most states are recording the results of a large number of
12 these tools on paper. Tools that were used in 42 states
13 are recorded on paper. In some cases, these may then be
14 converted to electronic format at a later time. That is,
15 of course, another step and has implications for reporting,
16 if that's something that would be required down the line.

17 And, again, in terms of how the data are used, in
18 many cases this information, since it is a rich source of
19 information on a beneficiary's health needs, is used to
20 help develop their care plan. Forty-one states using 73
21 tools reported using the assessments indeed to inform their
22 plans of care. And although a minority of the tools or the

1 tool documentation discussed payment issues related to the
2 use of the tool, there was some evidence that some states
3 are using the information from the functional assessment
4 tools in order to set payment rates in order to often
5 categorize beneficiaries into tiers to tie payment to
6 acuity.
7 And so there are two main policy questions that
8 I'd like to discuss with you today.
9 First, should states be required to each use a
10 single functional assessment tool across all LTSS
11 populations and programs? So this would be, you know,
12 hoping to use a single tool across, again, all populations,
13 all waiver programs, acknowledging that individuals have
14 different needs so it may require a more modular approach.
15 And there are states that are doing this and that have made
16 the investment at some time and expense in order to move
17 towards a single tool. We found a few states that have
18 done that. However, again, it requires a large time
19 commitment and financial investment, which may be one
20 reason why it hasn't been pursued by more states.
21 And the second policy question is: Should all
22 states be required to use the same tool or some set of

1 similar questions in order to report those results to the
2 federal government? So, again, requiring that states use a
3 tool or a set of questions that are similar would allow for
4 comparisons across state programs. We note via claims data
5 what Medicaid programs are paying for in terms of LTSS, but
6 cannot match that to the needs of beneficiaries to better
7 understand whether programs are meeting their needs and how
8 that may vary across states. However, additional data
9 reporting, of course, could pose a burden to states, and so
10 that's something to strongly consider as well.
11 So, again, the material that NORC pulled together
12 for us, it's a very large document that we can post on our
13 website as a resource. It contains information on all 124
14 tools as well as two summary tables with sort of different
15 detail, and that's something that we would like your
16 opinion on if that's something you would like to share with
17 the policy community. We're also interested in getting
18 your perspective on any additional work that you would like
19 to see conducted on this topic.
20 I look forward to your comments. Thank you.
21 CHAIR ROWLAND: Comments?
22 COMMISSIONER RILEY: It feels remarkably like

1 deja vu, an old issue, and it brings me back to sort of the
2 MDS debates when there was great resistance to standardized
3 nursing home eligibility. It seems to me we might have a
4 rich discussion to do a little bit of a historical dig on
5 what was the history of MDS, what was the resistance to it,
6 and how is it working now, because it's certainly a norm.
7 And I think it would be useful --
8 CHAIR ROWLAND: And, Trish, you might want to add
9 to that when is MDS being used for payment as opposed to
10 nonpayment.
11 COMMISSIONER RILEY: Exactly, what its functions
12 are and for what -- and the population's more narrow. And I
13 do think that the matrix is great and will be useful as a
14 public document. But it would be interesting to have a
15 focus group or engage some of the states since they have
16 targeted their populations differently and have different
17 sets of services across the first question about whether
18 one functional assessment can be used across the total
19 population without being a tome I think would require some
20 more brainstorming with states that might be really very
21 useful. And I think, again, whether it should be a
22 standardized assessment tool, which has some appeal, and

1 then reporting to the federal government, again, should be
2 informed by the MDS experience. What did we learn? How is
3 it used? Do states find it credible and useful data? Do
4 they use it? Do the feds use it?
5 CHAIR ROWLAND: I was going to interject before
6 Chuck has to step out, but he was commenting that the MDS
7 data, when used as part of RUGs and in payment, is a lot
8 more reliable than when it's just collected individually,
9 and so that might be something we'd want to really look at.
10 VICE CHAIR GOLD: I have a question about which -
11 - I'm not sure what was in the report, but it would be
12 interesting to me if the report showed -- there's two
13 differences. The question I have is whether this
14 overstates the fact that there are 128 forms or not, and if
15 the report had some information on whether on the same
16 dimensions or maybe it was a different instrument, but a
17 lot of them use the same scale, because ultimately, as I
18 understand it, one of the reasons we got into this was to
19 get some national data on what might be going on. And so
20 I'm not sure it's worth going back if it didn't do that.
21 But if the report had some sense of where these are
22 different and where these might be the same, it would be

1 worth maybe refining that a little to see what we might be
2 able to get out of what's there now and use that in terms
3 of considering any gaps and what the problem -- you know,
4 what the potential might be in moving forward.
5 COMMISSIONER SZILAGYI: This is a very similar
6 question, and a totally naive one. From a medical point of
7 view, I have a hard time imagining why physical functional
8 disability or mental functional disability or emotional or
9 developmental or even psychosocial disability should vary
10 that must across states. So I don't see why -- so my
11 question is actually there have to be better scales and
12 worse scales and scales that have been studied, and there
13 must be scientists in this field who would know what are
14 the best instruments to measure functional disability. And
15 so I would favor trying to converge upon those. That's
16 different than the payment issue or even potentially
17 eligibility, because there may be state variations in
18 eligibility. You know, but in terms of just measuring
19 functional disability, it just astonishes me that there's
20 such variability, unless there's less variability than it
21 seems, unless it's less than the 124.
22 COMMISSIONER RETCHIN: Yeah, I think this is

1 opening up a door that we probably need to go in, and I
2 think it's a perfect example where state experimentation
3 and innovation probably does not lead to more effectiveness
4 and efficiency. And there's a consequence of this that
5 I'll just mention and then use another example other than
6 MDS, and that's OASIS used for home health. And here's a
7 federal program that is able to -- I mean, you know there
8 are state variations in terms of -- well, there probably
9 aren't, but maybe there are in terms of the way the SNFs
10 are used or home health, and we know that people are moving
11 in between and have the same functional status but in
12 different settings that have great payment implications.
13 But I think in this case, the other unintended consequence
14 is when you have 124 different instruments for assessing
15 functional status, it's very unlikely that a private vendor
16 is going to be generating an electronic system. It's just
17 not worth it at the state level. In fact, even at OASIS,
18 it became almost out of reach for some of the big vendors
19 like Cerner. They didn't even develop it. So with this
20 many different instruments, I'm afraid that an iterative
21 process automated in the field or the like is unlikely to
22 be developed.

1 COMMISSIONER GABOW: I want to key off what Peter
2 said. It seems unlikely, knowing what we know about the
3 administrative and research capacity of most state Medicaid
4 agencies -- we've heard about that here -- that they would
5 have the sophistication to do the research at a level of --
6 at a level that is probably available to create the best
7 possible instrument. Now, maybe Minnesota that put $3.4
8 million into it, maybe they did. We don't know. But it
9 seems like this is an area where there must be research,
10 there must be good data. And so coming up with a single
11 instrument, which is modular -- I think the modularity of
12 it will be important -- that would be used by everyone
13 would give us the benefit of putting the science that we
14 know about disability into the practical application that
15 could be used to best give patients what they need and give
16 us at the federal level information to once again have
17 transparency and accountability for how our dollars are
18 being spent and whether they're being spent in a way that
19 best serves the needs of people.
20 So, I mean, this seems like -- I certainly think
21 that we should pursue this in the sense of a single
22 instrument across all states that's verifiable and based on

1 what we know about disability from a scientific
2 perspective.
3 COMMISSIONER CARTE: I was just wondering if we
4 should also be looking at -- I think Sheldon brought up
5 looking at physical functionality versus intellectual, but
6 would we not want to look at different long-term care
7 populations served by home- and community-based services?
8 There are some subpopulations like traumatic brain injury.
9 I'm not sure where they would fall, so it's just a
10 question.
11 But I'm really glad that we're pursuing this
12 because I never imagined at the outset we'd be looking at
13 124 different instruments, so I think anything that we
14 could do to urge more simplification and standardization
15 would be helpful.
16 COMMISSIONER COHEN: This is a great topic, and I
17 agree with Sheldon. I think it's a door we have to go
18 into.
19 I will say I think it is a tempting entry point
20 to sort of start with the tool and standardizing the tool,
21 but the reality is you don't come up with 124 tools without
22 -- like, that's a lot of tools, which means states are --

1 at least there's a lot of implementation and a lot of
2 history and a lot of stuff behind all that.
3 And so I think it's one thing to say, in a
4 perfect world, if we were building it today, we would
5 probably want everyone to use one. I think we would not
6 have a hard time probably coming to that conclusion, but
7 it's a different question, I think, what you do once you
8 have 124 with 124 different histories sort of in place.
9 And I think to just say the goal is a standardized tool,
10 it's a fine goal, but the burden associated with that is
11 going to be incredibly high if we are saying we really need
12 to take a deeper look into how we pay for things, how we --
13 if it's sort of part of a much larger effort in this space
14 and we can articulate the need for the standardized tool as
15 really essential to that, but just sort of do it as an
16 individual sort of building block for what we might do in
17 the future, I think we should be careful about that because
18 it is. It will be a terribly burdensome and difficult
19 thing to do to get 124 down to 1, if that's even -- and if
20 that's an appropriate goal.
21 I'm sure there will be -- there are different
22 opinions about whether or not one tool is appropriate for

1 every population that uses LTSS, and maybe you could get a
2 consensus around some number other than one, too, but I do
3 think it's hard just to tackle this from the question of
4 data collection in a vacuum of what you're trying to change
5 and do with it.
6 And that's not at all a critique of the paper at
7 all, but just in terms of how we think about it going
8 forward, I don't think we can be so narrow to just say --
9 tool.
10 COMMISSIONER RETCHIN: Yeah. I'd just make one
11 more point. That is that one of the most disturbing things
12 that you showed, Kristal, was that many of these tools were
13 made up by each state. They weren't like, "Hey, I'm going
14 to choose this one off the shelf," whereas Nebraska chose
15 another one. That's just mind-boggling, but it suggests
16 maybe in reinforcing Andy's point that there will be like
17 pride of ownership. It's got to be the Nebraska. It
18 almost sounds competitive. To have 124 suggests a systemic
19 effort or something. You'd think accidentally, they would
20 have stumbled upon the same tools, like the 124th. You'd
21 think that somewhere along the line, they would have said,
22 "Okay, enough."

1 It's a tool race, like an arms race.

2 MS. VARDAMAN: There are some similarities
3 amongst the tools in terms of what domains they assess, but
4 there are also a lot of differences, as you mentioned.

5 COMMISSIONER CARTE: And to that point, wouldn't
6 it raise the question of whether or not there shouldn't be
7 some independent look at the validity of the tools and
8 reporting on that?

9 MS. VARDAMAN: One of the characteristics they
10 did look at for us was whether it was validated. I don't
11 know if that information was available for all of the
12 tools, but we do have that for some number of the
13 inventory.

14 COMMISSIONER CARTE: Well, I would suggest that
15 that should be looked at and also what would be a minimum
16 validity needed per subpopulation.

17 VICE CHAIR GOLD: Yeah. I mean, it's kind of
18 hard to imagine, and this isn't my area, so maybe it's just
19 not relevant to some of the populations being assessed, but
20 that they don't have the ADLs or the IADLs or some part of
21 that in these tools. And it may be that they call them
22 different things and they have them reorganized different

1 ways, but if we knew --

2 COMMISSIONER RETCHIN: The Nebraska ADLs.

3 VICE CHAIR GOLD: -- that there were two or three

4 common assessment tools, maybe some of the clinicians on

5 the panel could tell you what they are. And I don't know

6 if the report shows that they are there at least.

7 I do think if we're having this reaction to this

8 number, so will a lot of other people, and it would be nice

9 -- if it's a big of an overreaction, it would be nice to

10 dial it down a little.

11 CHAIR ROWLAND: Having been around long-term care

12 issues for longer than I would like to say I've been around

13 them, this issue is not a new one, but it always comes up

14 as we have ways to decide what the right protocol level of

15 care is for someone who has different acute care illnesses

16 or even some of the chronic illnesses. But when it comes

17 to the need for ADLs and IADL assistance, we don't

18 necessarily have the same set of ways to measure who gets

19 it.

20 So the standard may be there, but how do you

21 measure who qualifies for the standard of three ADLs that

22 may be different?

1 And I think that what Kristal has done a
2 marvelous job of showing us is that as everyone has always
3 said about long-term care, there really is no single
4 measurement standard, and we're really out there trying to
5 figure out in different states, in different ways, who
6 qualifies for some of the home- and community-based
7 services, the developmentally disabled, who qualifies for
8 them, as over age-65, who qualifies for them on the basis
9 of mental incapacity.
10 And so maybe what we really have contributed here
11 is to say look at all these ways that are being measured.
12 There must be some common cores here that we're not quite
13 sure what they are, but we ought to think about really why
14 we want these measures. How are we going to use them? So
15 it's not just to know what the prevalence of the need for
16 long-term services and supports is. It's to try and figure
17 out either how to do better care planning, how to figure
18 out how to better relate payment, so that I think this is
19 not our attempt to decide what the core should be, but it's
20 just to identify if you're going to move forward on some of
21 these policy issues, you really need to be able, going
22 forward, to start to think about at least doing the same

1 kinds of things.

2 We've had commissions that spend months, years,
3 trying to come up with the measures of how we measure
4 access to care, how we measure children's health services,
5 how we measure maternal and child health care, but this is
6 that we don't have a common measure of long-term services
7 and supports.

8 And I would suspect that underneath this, there
9 is a commonality, but I don't know that anyone has ever
10 said, "This is the core way we do it."

11 Sharon.

12 COMMISSIONER CARTE: I would like to ask Kristal
13 if she thinks it's possible to take the information as it
14 is and to re-matrix it in terms of subpopulation or
15 condition because I think it would be helpful.

16 I notice on the list, many, many states will have
17 an instrument for those in nursing home settings or IDD,
18 intellectually-disabled community waivers, but I saw just
19 one or two that had to do with substance abuse, for
20 example. So if we look that up from that perspective, we
21 might see there are only one or two tools for some
22 populations, where you might see a commonality, a greater

1 commonality that way in some areas.

2 MS. VARDAMAN: Yes. So the inventory is in a
3 large Excel file, and so I have the ability to filter and
4 look at certain characteristics and how the others sort of
5 fall out.

6 COMMISSIONER CARTE: Well, that would be great,
7 if you could do that.

8 CHAIR ROWLAND: And our plan for releasing the
9 report itself is on the Web?

10 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. It's a very
11 big, unwieldy kind of thing, that you would need a large-
12 format publication, piece of paper to do it, so I think it
13 works best on the Web. The tables are extremely wide.

14 So we have sort of the core thing, and I think
15 now we just need to look and think about what the framing
16 is for it and then whether we wanted to also put some
17 conclusions on it about some of these things, but I think
18 we are pretty close.

19 CHAIR ROWLAND: Thank you.

20 And now we're going to turn to Policy Levers that
21 Affect Medicaid Spending. This is an attempt to begin to
22 build on the presentation that we had at our prior meeting

1 about the factors going into Medicaid spending, and this is
2 now the levers of how you might control that. And it looks
3 across the broad range, and so this is a conceptual
4 discussion that we're going to have to continue our work on
5 looking at what drives Medicaid spending and how to control
6 it.

7 And I guess Moira will start. Moira and Jim.

8 MS. FORBES: Yes. Thanks, Diane.

9 CHAIR ROWLAND: We've had Jim in the hot seat
10 today for a long time.

11 [Laughter.]

12 **### Policy Levers that Affect Medicaid Spending**

13 * MS. FORBES: All right. So, yes, as Diane says,
14 this builds on April's presentation at our last meeting on
15 trends in Medicaid spending.

16 As you know, there's a lot of interest at both
17 the state and the federal level at identifying budget
18 savings and in finding ways to reduce the rate of growth in
19 Medicaid spending.

20 Last spring, MACPAC was asked by both houses of
21 Congress, including both sides of the aisle, to explore
22 such mechanisms and their possible consequences. So this

1 session, again, building on the trends in spending, will
2 provide an overview of the levers available to state and
3 federal governments to hold down growth in Medicaid
4 spending and also some discussion of the potential effects
5 of using those levers.
6 And next month -- or hopefully January at the
7 latest -- we'll come back with more information on specific
8 policy proposals that have been raised by blue-ribbon
9 commissions tasked with looking at Medicaid spending.
10 So, last month, April talked a lot about the
11 components of spending growth, which are primarily: who is
12 covered and how many people are covered, what services are
13 provided, and how they're priced.
14 The following slides will provide more
15 information on the types of policy interventions or policy
16 levers available to the states and the federal government
17 that can have an effect on overall Medicaid spending
18 growth.
19 Different levers will have different effects in
20 terms of both their -- the magnitude of their effect on
21 spending itself as well as potential impacts on other
22 aspects of the program. Sort of the classic example is

1 reducing provider rates. Certainly, cutting provider rates
2 will lead to a reduction in Medicaid spending, but can
3 certainly have other effects in terms of provider
4 participation and access.
5 So, on each of the slides, we've tried to think
6 through some of the considerations that should be taken
7 into account when thinking about the various levers, and as
8 we go through the slides, we didn't try to be exhaustive.
9 We tried to provide a range of examples, but in your
10 discussion, you may certainly identify other levers that we
11 should be thinking about and other potential considerations
12 that should also be part of the discussion.
13 So, again, a slide you saw last month, total
14 Medicaid spending is equal to the number of people times
15 spending per person, and we've grouped the levers. There's
16 a lot of tools, actually, that the federal government and
17 the states have available to them, and we've tried to think
18 about it in terms of enrollment-related levers and then
19 ones related to spending, both what we pay for and what we
20 cover.
21 I'll hand it over to Jim after that. We did
22 identify there are an increasing number of approaches that

1 states and the feds are considering that focus more on
2 integration of different aspects of the program, and so
3 we've sort of made those into their own group.
4 So when we talk about enrollment or enrollment
5 policy changes, what we're often thinking about are
6 eligibility groups and the numbers of people covered. Many
7 of the levers here listed on this slide relate to
8 eligibility groups, the mandatory groups that federal
9 policy requires states to cover, the optional groups that
10 states can cover, the waiver groups that states can request
11 permission to cover, and that the federal government can
12 approve or not.
13 Eligibility processes themselves can also affect
14 the number of eligible persons who enroll in a program, and
15 we've discussed as a Commission before some of these
16 processes, such as Express Lane Eligibility. The extent to
17 which states implement processes like that, they can help
18 people who are eligible actually come on.
19 Also, because eligibility for Medicaid generally
20 includes an income component, federal policy around the
21 actual definition of poverty levels and so on, and what
22 types are income are counted can affect Medicaid

1 enrollment, and so there's a lot of levers here at both the
2 federal and the state level.
3 Changes in enrollment policies do require a
4 number of considerations, and I would say that this
5 Commission certainly thinks through a lot of those
6 considerations as it thinks about changes in CHIP
7 eligibility policy -- the financial and health status of
8 currently covered populations, the number of currently
9 uninsured people, the availability of alternative sources
10 of coverage, all things that would be taken into account in
11 a discussion of making a change in terms of eligibility
12 policy or enrollment policy.
13 As we've talked a lot about before, there are
14 very few federal policies that directly affect the prices
15 paid to Medicaid providers, and states have considerable
16 flexibility in determining payment methods and amounts.
17 Federal statute generally requires Medicaid
18 provider payments to be consistent with efficiency,
19 economy, quality, and to ensure equal access, but beyond
20 that, there's not a lot of federal policy that specifically
21 directs payment amounts. There's the upper payment level
22 rule. There are some rules around cost-based reimbursement

1 for certain provider types.

2 But, mainly, states have a lot of flexibility.
3 They develop their rate-setting processes. They develop
4 their fee schedules for different services and programs.
5 They establish supplemental payments. They can implement
6 pay-for-performance programs. They can negotiate
7 supplemental pharmacy rebates. They can use competitive
8 bidding to bring down prices. There's a lot of ways in
9 which states manage prices.

10 Of course, there are limits to how much states
11 can do this. Market dynamics is obviously a big part of it.
12 The payment policies of other payers, particularly
13 Medicare, certainly have a lot of influence over what
14 providers are willing to accept.

15 States can't set payments so low as to jeopardize
16 access or quality, and some more sophisticated payment
17 mechanisms that states may want to implement may be sort of
18 beyond their internal administrative capacity to actually
19 implement.

20 The other component of spending per person
21 besides prices is service volume and intensity, and sort of
22 similar to eligibility on the federal side, a lot of levers

1 have to do with the definitions of the mandatory service
2 categories, that all states have to cover in Medicaid, the
3 optional services and the waivers.
4 States can determine which optional services to
5 cover and are largely responsible for defining the amount,
6 scope, and duration of each covered service.
7 States can implement a lot of different tools to
8 manage utilization, including prior authorization and
9 formularies. They can implement cost-sharing policies.
10 There are federal bounds around a lot of these state
11 levers, but for the most part, states actually have a fair
12 amount of leeway in deciding which tools to implement and
13 how to do them.
14 Administrative complexity again -- oh, sorry. I
15 should have mentioned program integrity is both a federal
16 lever and a state lever. They share responsibility for
17 those activities, and reducing fraud, waste, and abuse is
18 another way to help contain costs.
19 But related to that, administrative complexity
20 is, again, a challenge for states. While in theory, states
21 could always implement more specific coverage policies and
22 tighter utilization controls to help control spending,

1 which requires a lot of state investment and activity. It
2 can also discourage providers from participating and can
3 potentially harm quality, if not implemented effectively.
4 So, with that, I'll turn it over to Jim.
5 Hopefully, he's had enough of a break.
6 * MR. TEISL: Thank you. So the preceding slides
7 obviously address levers that relate directly to the
8 spending drivers that April talked about last month and
9 that we previously discussed. Moira mentioned there are
10 some others that don't fit as clearly into these drivers,
11 but that we also wanted to raise, and they fall under these
12 categories that we've called value-based purchasing and
13 funds available.
14 Value-based purchasing initiatives overlap the
15 earlier drivers. They're generally intended to affect
16 spending through price-based incentives to change the
17 volume and intensity of services. And examples of levers
18 that the federal government has used to promote value-based
19 purchasing, most of these recently, include guidance on
20 states' ability to implement accountable care organizations
21 through state plan authority and specifically under the
22 statute allowing primary care case management. The federal

1 government can permit waivers of things like freedom of
2 choice based on providers' meeting specified value
3 criteria. And CMS also can provide technical assistance,
4 for example, through CMS' Medicaid Innovation Acceleration
5 Program, which is going on right now.
6 At the state level, examples of the types of
7 levers that influence spending through value-based
8 purchasing include things like the actual payment method
9 characteristics like the benchmarks that bundled payments
10 are compared to, the thresholds that have to be met in
11 order to for providers to share in savings. Another
12 example would be qualification tiers for patient-centered
13 medical homes to qualify for higher per member per month
14 payments.
15 States also can affect spending through the
16 selection of quality metrics and the quality thresholds to
17 qualify for things like shared savings, also decisions
18 regarding the inclusion or exclusion of certain costs in
19 total cost of care calculations, for example, whether
20 behavioral health costs, for example, are part of the total
21 cost of care benchmark that provider spending is compared
22 to.

1 Considerations for the use of these levers
2 include the fact that, first, the jury is still out on the
3 actual effects that they have on spending. It's also
4 necessary to consider the effects on things like the
5 relationships among providers, under things like
6 accountable care organizations or bundled payments, also
7 the possible effects on quality and issues related to
8 enrollee protections. And as I listened to Moira talking
9 about administrative complexity, I added it to both of
10 these because administrative complexity is a consideration
11 basically under all of these things, all of the different
12 levers at both the federal and the state levels.
13 The state and federal governments can also affect
14 spending through levers that we sort of loosely categorize
15 under the heading "funds available," and these affect the
16 amount of funding for the program and then potentially the
17 balance between the state and federal shares of that
18 funding. Examples of things we would include here include
19 the federal government can provide enhanced levels of match
20 for certain things, like it has for IT system development,
21 the administrative cost of medical professionals, or a
22 higher match for the new adult group.

1 It can also affect states' ability to raise the
2 non-federal share from certain sources, which we've talked
3 about at length, such as the 6 percent safe harbor
4 threshold that applies to states' use of health care-
5 related taxes. The federal government can determine trend
6 assumptions for establishing spending limits, like under
7 1115 demonstrations. And perhaps most significantly, the
8 federal government can even change the way in which federal
9 funding is determined and allocated, and under this sort of
10 financing structure bullet is where we would include things
11 like block grants, per capita caps, the type of shared
12 savings proposals that Alan Weil and Mark McClellan
13 described to us in a previous meeting.
14 State examples that fit under this category
15 include actually raising the non-federal share of Medicaid
16 spending through the use of things like health care-related
17 taxes, and identifying things that qualify as designated
18 state health programs under 1115 demonstrations. States
19 can also seek to improve their match rate for certain
20 expenses, for example, having managed care organizations
21 perform certain administrative functions. We talked
22 earlier about the possibility for states to, rather than

1 making DSH payments, make other supplemental payments like
2 under the upper payment limit or other types of payments
3 which in some cases might qualify for a higher match rate,
4 for example, for the adult group.
5 As with other levers, and maybe even more than
6 with other levers, the use of these has important
7 downstream effects on things like enrollment, prices, the
8 types and amount of services provided. There are also
9 important considerations such as the balance between
10 assuring efficient use of state and federal funds and at
11 the same time permitting flexibility under the program.
12 So, in closing, as Moira mentioned at the start,
13 both federal and state governments have a wide array of
14 policy levers that can affect program spending. It is
15 important to remember, however, that most of these have
16 effects beyond just spending levels themselves. We list
17 several here. There are no doubt others that you might
18 want to raise. We look forward to your thoughts on the
19 material as well as other things you might like to hear
20 more about in the future.
21 As Moira mentioned, we've started work to
22 identify specific savings proposals over the past 30 years,

1 and I think we're hoping by January to be able to bring
2 those results to you.
3 COMMISSIONER MILLIGAN: So I have a few comments.
4 I think this is a good overview. I wanted to identify a
5 few things I think that are missing that I think are
6 helpful since the slide deck is -- my expectation is that
7 you all are going to put it online, and I just want to
8 offer some suggestions about that, if that's correct. But
9 maybe I'll start while -- so get me to Slide 6, please.
10 And I'll use my first example here to illustrate a point.
11 One of the state levers here is payment rates,
12 and I think in general, unlike a lot of parts of Medicaid,
13 states have a lot of flexibility about provider rates.
14 There isn't, with a few exceptions, mandated rates. But I
15 think one of the sort of points I want to make from a --
16 the way this is presented is as if the state has that
17 lever, state discretion, a state can choose to act. And I
18 think from a state Medicaid agency’s perspective, the CMS
19 review and approval of a state plan amendment and whether
20 CMS believes that the rate reduction, for example, is
21 appropriate, from a state's point of view, it isn't quite
22 as cleanly a state lever as it might be portrayed here.

1 CMS will review it in terms of whether the rates are
2 adequate to provide access reasonably commensurate with
3 other insured people per the Social Security Act, but that
4 back and forth with CMS, I think states would perceive that
5 this isn't a lever that can kind of be just triggered.
6 And so I guess the broad point I want to make
7 about this -- and I'll give another example in a second --
8 is that the CMS review and approval of a state plan
9 amendment and the interplay from a federalism point of view
10 of roles, it isn't quite as cleanly a state lever as this
11 slide would portray. And I understand the importance of
12 access and all that. I just think that it's not -- the
13 state doesn't have that lever to unilaterally pull, is my
14 point.
15 If we can go to Slide 7, I'll make another
16 illustration about this. The state lever here that's
17 identified as coverage of optional and waiver services,
18 states also have as a lever coverage of mandatory services,
19 and using the amount, duration, and scope part of Medicaid,
20 and I want to, just for everybody's -- kind of level set
21 with everybody, the amount, duration, and scope part for
22 the mandatory benefits says that, in general, states have

1 discretion about the amount, duration, and scope of a
2 benefit. EPSDT protects it for kids, so I'm really talking
3 about adults. But I want to give an example of this byplay
4 with CMS and states to illustrate the point.
5 Hospital services are a mandatory benefit. A
6 state presumably could say: “We're only going to cover 20
7 inpatient days a year; we're going to set an amount,
8 duration, and scope limitation.” CMS has a rule that has
9 never been published, never been promulgated in sub-
10 regulatory guidance, that says that if a state wants to
11 change the amount, duration, and scope of a mandatory
12 benefit -- and I'll use the 20 inpatient days example -- it
13 has to be sufficient to provide access to completely meet
14 the needs of 90 percent of the state's Medicaid
15 beneficiaries. And so you can't set a level that's only
16 five inpatient days a year if the vast majority -- you
17 know, the majority of your Medicaid population needs more
18 than five days. But you could set a level at 20 if for 90
19 percent or more of your population 20 is enough.
20 That 90 percent rule has never been put in a reg.
21 It has never been put in a Medicaid Director letter it has
22 never been put in any kind of sub-regulatory guidance. But

1 it's applied when states propose changes in their state
2 plan amendments.
3 So a couple of points I want to make about this:
4 Mandatory benefits themselves, states have some levers
5 using amount, duration, and scope; CMS gets involved; and
6 there's a lot of lack of clarity about that from a state
7 budget, cost containment, all of those. So I just wanted
8 to illustrate that.
9 The other part on this slide that I want to make
10 is you mentioned in the title volume and intensity, and I
11 would add mix. And I'll give you an example of what I mean
12 about that.
13 Getting a generic medication as opposed to a
14 brand medication, it might be the same volume, it might be
15 the same number of pills. But the mix matters in terms of
16 expenditures. And the example -- and I've used this
17 example at an earlier MACPAC meeting, maybe in the spring -
18 - is the increasing trend of hospitals employing
19 physicians, and so the change in mix for physician services
20 that used to be more of a stand-alone clinic and now more
21 of a hospital-based where there's often a facility
22 associated with it, volume, intensity and mix I think is --

1 I would add mix to that list.

2 And then I guess my last -- it's on the next
3 slide, if you don't mind, on Slide 8 -- two comments about
4 additional policy levers. I didn't see a lot of discussion
5 about cost sharing from beneficiaries, and so charging
6 beneficiaries some amount to get a prescription or some
7 amount to go the ED for a non-emergent visit, let's say,
8 that is a tool. It's a controversial tool, as many of these
9 are. Is it going to reduce costs because it's going to
10 discourage access? Is it going to reduce costs because
11 states are going to cut the provider fees, assuming the
12 providers will collect the difference with a co-payment?
13 But I think we need to mention beneficiary cost sharing.

14 CHAIR ROWLAND: Chuck, I think it's in both 6 and
15 7.

16 COMMISSIONER MILLIGAN: Okay.

17 CHAIR ROWLAND: But it's just not standing out
18 too big --

19 COMMISSIONER MILLIGAN: It's not standing out
20 because it -- to me, it affects utilization and mix, and it
21 can't effect --

22 CHAIR ROWLAND: It's in both 6 and 7.

1 COMMISSIONER MILLIGAN: All right.
2 MS. FORBES: We went back and forth several times
3 and put it on both slides because we were, like, are they
4 cutting prices --
5 COMMISSIONER MILLIGAN: All right. I'm sorry.
6 MS. FORBES: -- or are they trying to influence
7 utilization?
8 COMMISSIONER MILLIGAN: I'm sorry.
9 MS. FORBES: I probably just did not say enough
10 about it. Sorry.
11 COMMISSIONER MILLIGAN: Thank you for throwing
12 yourself under the bus, but I should be the one under the
13 bus. So I appreciate that. I'm sorry I mistook that. But
14 I think that delivery system -- and maybe Mark would sort
15 of just -- another lever is how you use delivery system
16 changes in general. So I'll stop there. Thank you.
17 VICE CHAIR GOLD: I have a question, and I guess
18 it's trying to sort out, as I was listening to all this --
19 I mean, this could be our entire charge or it's how you run
20 a program or what's involved. And I was trying to think
21 through how this helps us -- or how you're going to use it
22 to address concerns, and I'm wondering if it might not be

1 helpful to sort of think about how broader strategies
2 affect which mix of these things you focus on, because you
3 could get lost in looking at each of these. Just Chuck's
4 description of the complexity of one of them, you know, was
5 enough to keep staff occupied for days. And I wondered if
6 for purposes of thinking through strategies and their
7 responses sort of whether there are five or six -- and
8 maybe this comes out of some of the options people have
9 looked at before, but different strategies that make the
10 existing program more efficient or recasts it in certain
11 ways or do other things that perhaps are different packages
12 of these that may take it up a level and allow sort of you
13 to get to the end faster might be helpful. But I'm not
14 sure where you're intending to go with this, but that was
15 kind of a reaction, and I wondered if you thought that
16 might be helpful.
17 EXECUTIVE DIRECTOR SCHWARTZ: So I can clarify
18 sort of the train of thought around this. These will go on
19 the web as they are because the slides for all our meetings
20 are put up as part of the public record.
21 We thought -- and I thought, so I will take
22 responsibility for this, that there's a conversation to be

1 had here in advance of the conversation of what has been
2 done to be able to sort of put out all the tools out there,
3 and I think it's totally fair, Chuck, what you're saying
4 about, you know, how strong some of these levers are and
5 how much they are in the state camp versus the federal camp
6 is useful conversation.

7 When we get to a conversation about looking back
8 over time of what has been tried, what has been
9 implemented, what has not been implemented, either because
10 of the things that have not been implemented, you know,
11 there's a number of reasons why not, but we can also say
12 what are those strategies trying to do and which of these
13 levers are they engaging and which ones sort of are there
14 no matter what.

15 So, Marsha, that's the idea. This is sort of
16 we're on the path to what, you know, we've been asked to do
17 by the Congress, which is look back and see what has been
18 tried and raised in the past, in part out of the sense of
19 “don't reinvent the wheel”, but also in part to be able to
20 -- for this Commission to comment on either the
21 effectiveness or the desirability of those sorts of things
22 looking forward.

1 So that's the conversation to be had in the
2 months ahead, and this is just a building block towards
3 that.
4 CHAIR ROWLAND: And I do think the difficulty
5 here is that we're talking about two very different levels.
6 We're talking about changes for the most part that are
7 under current law and that are tools that states can use
8 and a few things the federal government can do. And then
9 we're talking about the big issue of overall financing and
10 how you use overall financing at least as a tool at the
11 federal level to contain federal expenditures. And that
12 brings on a host of other issues that then affect all of
13 these other changes that were listed at the micro level.
14 And so we're really just trying to look at what
15 the whole sphere is, and then we'll have to weigh the
16 differences in terms of the levers and their ultimate
17 impact. These things that are cost sharing and formularies
18 and service limits, these are all things in place today,
19 and they don't really change -- they are state-determined,
20 which is what's here, as opposed to federally determined.
21 But obviously the extent to which the federal government
22 lets the states use these tools affects overall spending as

1 well. But it's not in the same plane as the federal
2 government deciding to say "we're only going to pay X
3 amount of money per person" or "we're going to be like CHIP
4 and set out an allocation formula." And I think as we
5 look, as we're requested to do, at some of the prior
6 proposals, we can sort them into these two camps as well.
7 EXECUTIVE DIRECTOR SCHWARTZ: There's also a
8 relevance both in terms of what, you know, states do in
9 every budget cycle in terms of thinking about what they can
10 do to meet a target that's been set for them, and then also
11 if you think about some of the larger financing reforms
12 that have been suggested, what allows states to then
13 function within a cap or a block grant or any of those
14 approaches.
15 CHAIR ROWLAND: It's interesting that if you go
16 back to the history of Medicaid, as many of us have looked
17 at the 50th anniversary, the argument for why states would
18 have to put a state share in was that that was the ultimate
19 cost containment mechanism, that because states would have
20 to raise a share of the spending, they would have an
21 incentive to not raid the federal treasury and would hold
22 down overall spending and they would make the program meet

1 their state's needs.

2 Obviously, in the era of supplemental payments
3 and Medicaid maximization, those tables got turned around a
4 little, and Congress came back and did some changes. But I
5 think we are still looking at the ultimate tension of
6 federalism between the federal government and states. And
7 so some of this detail here obscures the big reality of who
8 pays for what and what are the incentives in the system.

9 COMMISSIONER MILLIGAN: I think all of that is
10 helpful, and I may have gone too granular with some of my
11 comments. I think part of what I was trying to say is that
12 this list, it would apply in similar ways to any insurance
13 product, commercial or otherwise, who you cover, what they
14 get, what the authorization rules are, what the payment
15 rates are, what the volume is. That's any insurance.

16 And so I think what I was trying to -- and I
17 think you all did a better job -- what's been animating the
18 ongoing, for many years, conversation about Medicaid budget
19 and Medicaid financing, I would say two things. One is
20 just the overall effect on the federal budget, and then the
21 second is the federalism issue of kind of state and the
22 federal government's roles in kind of co-administering this

1 program.

2 And I think this sets up that conversation, while
3 I just wanted to try to make a distinction between kind of
4 a framework that could apply to any insurance, to help set
5 up the foundation for why this is such an ongoing area of
6 conversation.

7 VICE CHAIR GOLD: And I'd like to add just one
8 third thing to yours. You said there were two main things
9 going on. The third is all the unmet needs that are out
10 there, and I think that's behind some of this -- what
11 you're doing, what you're not doing, what you're leaving
12 off the table -- because that's been -- and the Commission
13 has done a great job of showing over time, what role that
14 has played in the growth of the program as it picks up some
15 of the unmet needs. So I think that's the third strand
16 that weaves through here.

17 CHAIR ROWLAND: Trish.

18 COMMISSIONER RILEY: The last conversation was
19 sort of how we're going to use this, because when I think
20 of policy levers, I think of the fundamentals, which is
21 Congress and legislatures and the courts, which are big
22 drivers of spending, and so I think we need to put that in

1 a context a little bit. But maybe policy levers aren't
2 quite -- we're really talking about tools. We're not
3 talking about the broad policy agenda that drives spending.
4 We're talking about the tools that the state and federal
5 government have to deal with that reality.
6 CHAIR ROWLAND: Maybe we're going to label this
7 afternoon, "The Afternoon of Tools."
8 COMMISSIONER RILEY: Tools.
9 [Laughter.]
10 CHAIR ROWLAND: Either long-term care or
11 financing.
12 Patty and then Andy.
13 COMMISSIONER GABOW: I know this is shocking from
14 someone who wants simplicity, and maybe I'm just not seeing
15 the picture at the right level. But slide 4, which has
16 Medicaid spending just in two bins, seems like it's overly
17 simplistic. I mean, it seems, as we talked about this
18 morning, DSH -- and we talked about UPL -- that Medicaid
19 special payments somewhere need to be on this chart.
20 And I also think this -- I know it's embedded
21 later on, the whole idea that what -- I think there's
22 something about the fact that it's 56 programs, and that

1 it's a state federal program, is driving spending in terms
2 of duplication and waste, and probably more possibilities
3 for waste and fraud.

4 Somewhere in this, is missing on this picture,
5 and the same thing about the spending per person, which was
6 talked about a little bit, but it seems that there's more
7 in that bin than what is there. Prices may cover a
8 multitude of sins, but maybe it's better to tease that out
9 a little bit. It's the payment methodology. It's the
10 providers who are getting paid. It's the marketplace. If
11 you're in a state that has no managed care, it is going to
12 be different.

13 And I also think something in that bin of
14 spending per person is the administrative methodology. I
15 mean, we talked about how express lane eligibility saved
16 money. So somewhere in price, there's -- it's maybe too
17 bundled. And I know that's hard to believe that I want to
18 make it more complicated.

19 CHAIR ROWLAND: It is indeed hard to believe.

20 [Laughter.]

21 CHAIR ROWLAND: Actually, why don't you be more
22 transparent, so that probably fits?

1 EXECUTIVE DIRECTOR SCHWARTZ: The staff has just
2 made a resolution never to draw a picture ever again
3 because whenever we do, we get in trouble.
4 COMMISSIONER GABOW: No, no. That picture of
5 CHIP that you gave us, that's fine, with the different
6 things.
7 CHAIR ROWLAND: Complicated one.
8 COMMISSIONER GABOW: Great.
9 CHAIR ROWLAND: A complicated picture.
10 EXECUTIVE DIRECTOR SCHWARTZ: No, that's data.
11 That's not like a flow diagram. Flow diagrams, we're
12 terrible at it.
13 COMMISSIONER GABOW: But any rate, the other
14 point I just want to make, which won't surprise you, is
15 that I think we've gone somewhere in this discussion that
16 the other approaches, whether they're old approaches being
17 looked at newly or new approaches like per capita caps --
18 well, as sort of block grants federalizing Medicaid,
19 somewhere those are also options at a higher level than at
20 a granular level. And I think they belong somewhere in
21 this deck.
22 I understand that it's a lot of --

1 CHAIR ROWLAND: They're not as laid out as you
2 would like, but they begin to be in this policy levers,
3 funds available, but it really -- that has a lot more going
4 on in it than -- it's not equal to all the other boxes that
5 we've looked at.
6 Now, I forgot. I had Patty, and then I had, I
7 guess, Andy and Steve. Okay. I lost the page I wrote your
8 names down on.
9 COMMISSIONER COHEN: I just wanted to sort of
10 mention again -- and I think this lever sort of falls
11 probably under value-based purchasing or maybe volume and
12 intensity, but there's all of this work going on right now
13 across the delivery system and thinking about whether we
14 efficiently use the delivery system and whether or not
15 there are a lot of expenses, hospitalizations and
16 otherwise, that are unnecessary and preventable and can be
17 handled by better outpatient, less expensive care.
18 I will call this a giant sort of hope in theory
19 that people are working very hard to just sort of test and
20 implement, and there's lots of evidence and certain sort of
21 configurations in ACOs and otherwise that you can make some
22 -- you can really either reduce spending or reduce growth

1 by really tackling some of those sort of things that result
2 in a lot of hospitalizations, and there's probably a lot of
3 evidence of that it may not be as promising as we think.
4 But I will say that is the big conversation going
5 on right now in the delivery system, and I just want to
6 make sure that we at least sort of describe that as part of
7 our sort of thinking about opportunities for making
8 Medicaid -- it's probably Medicaid's ability to influence
9 that is through payment and through value-based payment,
10 but I just wanted to give it a little bit more sort of
11 oomph and explanation because that's a lot of the bet
12 that's being played in Medicare and in the rest of the
13 delivery systems, that there are opportunities to do this
14 through changes in the delivery system and the higher-
15 performing primary care and other things.
16 And, again, it's not a sure thing. The evidence
17 is probably not completely set whether it works or not, but
18 it is what everybody else is doing, so I sort of want to
19 give it a little bit more attention than a bullet because
20 Medicaid operates in a context. And for the most part,
21 physical health care at least uses mostly the delivery
22 system that the other major payers do too. So being

1 aligned with those efforts, if we see they are promising,
2 is an important strategy to keep in mind.
3 COMMISSIONER WALDREN: I don't do it very often,
4 but I am going to disagree with Patty. I like the
5 simplicity of that slide. I also like --
6 CHAIR ROWLAND: That's why we have you sitting
7 next to her too. You can do that.
8 COMMISSIONER WALDREN: Yeah. And I also like the
9 idea of using the policy levers as the organizing kind of
10 principle because what I think it allows us to do, for
11 example, is pricing. We can, all of a sudden, deep-dive
12 very, very deep into pricing and all the complexities of
13 it, the deep interrelated ontology of pricing, but then at
14 the end of the day, we can say if price goes up or price
15 goes down, what does that mean?
16 Another thing I like about the policy levers is
17 it allows us also then to drive down all the things that
18 Chuck talked about as what happens if you use that lever
19 and raise it up, what does that mean? If you lower it
20 down, what does that mean? And what are all the barriers
21 and issues around raising it or lowering it? So I really
22 like the way that this is laid out. It allows at a high

1 level, but drops into different levels and come back up. So
2 I really like it.
3 CHAIR ROWLAND: Maybe we should end on that note.
4 Thank you. I mean, this is just the beginning of
5 what is obviously going to be a very long and intense
6 discussion of both the spending controls within the program
7 today but also looking at options for how to change the
8 incentives in terms of both what is covered and who is
9 covered and how and the relationship between the federal
10 government and the states around that, so thank you.
11 So now we'll take a 10- or 15-minute break, and
12 then we'll reconvene. So we'll reconvene at 2:45.
13 * [Recess.]
14 CHAIR ROWLAND: Chris, you are sitting there
15 looking very diligent, and my Commission members are going
16 to come to order.
17 Obviously, one of the topics of hot discussion
18 increasingly is the cost of prescription drugs, and in
19 Medicaid, Trish has raised several issues around some of
20 the challenges of some of the new drugs coming onto the
21 market. But we're going to ask Chris to at least review
22 with us trends in Medicaid spending for prescription drugs,

1 and we're thinking that this could lead to an issue brief
2 that we'd put out or to potentially some inclusion in one
3 of our reports.

4 **### Trends in Medicaid Spending for Prescription**
5 **Drugs**

6 * MR. PARK: Thank you, Diane, and I think this is
7 a nice segue from the previous session, where I'll provide
8 some more concrete examples of some of the factors that
9 determine spending that you just discussed in a prior
10 session.

11 As Diane mentioned, prescription drug spending
12 and prices have garnered a lot of attention recently,
13 particularly with the introduction of new high-cost drugs
14 for the treatment of hepatitis C and large price increases
15 on a certain number of drugs.

16 CMS's Office of the Actuary has identified
17 prescription drug spending as one of the key factors in the
18 recent increase in health care spending for 2014. They
19 projected that overall prescription drug spending went up
20 about 12.6 percent versus a 4.8 percent increase for all of
21 the other services. And their projections for Medicaid
22 were even higher. They projected a 23 percent increase in

1 prescription drug spending for 2014.

2 So, today, I'll be presenting data on historical
3 drug spending in Medicaid and some of the factors that have
4 led to the recent trends in spending. First, I'll briefly
5 discuss the importance of drug rebates and their impact on
6 spending and policy. As you'll see, Medicaid drug rebates
7 are substantial and they reduced gross spending by almost
8 half in recent years.

9 Next, I'll present some data on historical drug
10 spending. After a few years of low to moderate growth,
11 spending increased significantly in 2014.

12 Next, I'll discuss some of the drivers of recent
13 spending, and you'll see primarily a lot of the spending is
14 impacted by enrollment growth due to Medicaid expansion and
15 the use of high-cost drugs.

16 And, finally, I'll discuss some of the tools that
17 Medicaid has to manage drug utilization and spending.

18 Throughout the presentation, I'll be using the
19 terms gross spending and net spending, and I want to
20 briefly discuss kind of the difference. Gross spending
21 reflects the actual payments made to the pharmacy to obtain
22 the drug. Net spending accounts for the rebates that

1 manufacturers provide to Medicaid, and there are a couple
2 of different types of rebates.
3 First, there are federally mandated rebates that
4 the manufacturers must provide. These are statutorily
5 defined and it's based on a condition that the
6 manufacturers must provide these rebates in order to be
7 eligible for federal funding for their products. In
8 exchange for the rebates, the state must generally cover a
9 participating manufacturer's drugs. They do have some
10 options to use tools like prior authorization and preferred
11 drug lists to manage the use of the drugs, but in general,
12 they must provide some level of coverage for a
13 manufacturer's products.
14 Additionally, states can negotiate additional
15 rebates called supplemental rebates with manufacturers.
16 These are similar to the rebates that you might find on the
17 commercial or Medicare side, where the manufacturers are
18 offering these rebates to kind of reduce some of the
19 restrictions on their drugs.
20 The data I'll be presenting comes from two
21 primary sources, and there are some differences between the
22 sources due to the purpose of the data and also the timing

1 of when they're collected.

2 The first data source is the CMS Financial
3 Management Report. These reports are submitted to CMS by
4 the states to claim federal match. They provide aggregate
5 spending for different types of service. In terms of
6 prescription drugs, they provide spending for fee-for-
7 service outpatient drugs. But they do not actually
8 identify, like, spending on particular services for managed
9 care. They only identify the total capitation payments
10 made to the managed care plan. Additionally, the CMS-64
11 provides fee-for-service and managed care rebate
12 information, and this is the only public source we have in
13 terms of knowing how much rebates a state actually
14 collected.

15 The second source comes from the Drug Rebate
16 Utilization Data. These are the data that states provide
17 to CMS and manufacturers in order to invoice for the
18 rebates. It provides claims units and gross spending by
19 the national drug code for both fee-for-service and managed
20 care claims. Managed care claims were just recently
21 collected due to the ACA, the Affordable Care Act,
22 extending the federal rebates to the managed care programs.

1 Additionally, and here's one of the differences
2 between the two sources, some physician-administered drugs
3 are eligible for rebates, and so the Drug Rebate
4 Utilization Data will contain information on these
5 physician-administered drugs, where other sources, such as
6 a CMS-64, usually contain that spending within, like,
7 physician types of service.
8 So, this chart shows historical fee-for-service
9 spending from 2002 to 2014. Now, I'm going to point out
10 kind of a couple of distinct trends that you will notice
11 where the dotted lines are.
12 First, from 2002 to 2005, this is before Part D
13 was created, and you'll see kind of a steady increase in
14 both gross and net spending. After Part D was created,
15 Medicaid no longer had responsibility to pay for most of
16 the drugs that eligibles who are dually eligible for both
17 Medicare and Medicaid would receive. All of that spending -
18 - most of that spending reverted to Part D and it was
19 Medicare's responsibility. And, so, you'll see a steep
20 decline in fee-for-service spending around 2006.
21 One thing I should note is that states do have a
22 responsibility to pay for some of Part D through what are

1 commonly referred to as claw back payments, and those
2 payments are not included in this data.
3 During this period between, like, 2007 to 2010,
4 after Part D, you'll see that gross spending has a pretty
5 moderate increase, but net spending has remained fairly
6 flat, and this is due to the total amount of rebates kind
7 of increasing over this period.
8 In 2010 with the Affordable Care Act, as I
9 mentioned, the Affordable Care Act extended rebates to the
10 managed care program, and so the decrease in spending that
11 you see in 2011, 2012, and 2013 is a reflection of states
12 moving the prescription drug benefit from fee-for-service
13 to managed care or implementing new managed care programs.
14 So, this isn't necessarily a decrease in total drug
15 spending. It's more of a reflection of a shift in payers.
16 This next chart shows both managed care and fee-
17 for-service spending using the Drug Rebate Utilization
18 Data, and I just want to point out that some of these
19 numbers will be different due to the different sources.
20 The prior chart used the CMS-64 data and this uses the Drug
21 Rebate Utilization Data.
22 The first thing that I'd like to point out is

1 that drug rebates are substantial. As you can see over
2 this four-year period, the drug rebates were almost half of
3 gross spending. So, there's a significant reduction in the
4 final net spending that states make.
5 Additionally, you can see that the shift to
6 managed care that I mentioned earlier. In 2011, managed
7 care was about 14 percent of gross spending. In 2014, it's
8 almost half. It's 47 percent. And, so, there's a pretty
9 significant shift in taking spending for prescription drugs
10 from fee-for-service to managed care.
11 Another trend that I would like to point out is
12 that from 2011 to 2013, you see that gross spending trends
13 are fairly modest and net spending trends are also fairly
14 modest, and there's even a little decrease from 2012 to
15 2013. But this changes and spending in 2014 increases
16 significantly. It's a 19 percent increase on net spending.
17 In terms of this increase in net spending, the
18 rebates have remained fairly constant in terms of the
19 proportion of gross spending. It's been between 44 and 49
20 percent of gross spending in these four years, and so a lot
21 of the increase in 2014 is due to an increase in gross
22 spending.

1 These next few charts are going to show some of
2 the components that are driving the recent trends in gross
3 spending, and I'd like to point out the upcoming tables are
4 all in calendar years versus fiscal years of the two prior
5 charts, and the reason we're using calendar years on these
6 tables is to better capture the effect of the Medicaid
7 expansion that went into effect in the beginning of 2014
8 and also to capture a little bit more experience for the
9 hepatitis C drugs that recently came onto market in late
10 2013 and 2014.
11 This table shows the change in gross prescription
12 drug spending from calendar year 2013 to 2014 between
13 Medicaid expansion states and non-expansion states. As you
14 can see, in the expansion states, we see about a 25 percent
15 increase in gross drug spending, compared to a 14 percent
16 in the non-expansion states.
17 This ten percentage point difference does give
18 you a sense of how much, of the spending change in the
19 expansion states due to the increase in enrollment.
20 However, the data don't allow us to specifically identify
21 how much of this increase is due solely to the Medicaid
22 expansion.

1 I'd like to point out that Kaiser Family
2 Foundation recently released their 50-state survey, and as
3 part of that, they did a survey in terms of changes in
4 total Medicaid spending between expansion states and non-
5 expansion states, and total Medicaid spending increased
6 about 17.7 percent in expansion states versus 6.1 in non-
7 expansion states. So, the difference between expansion and
8 non-expansion states on drug spending kind of reflects a
9 similar difference in the total amount of spending.
10 As Chuck mentioned earlier, one of -- a driver of
11 spending, particularly on prescription drugs, is the mix of
12 prescription drugs used. And, so, this chart shows the mix
13 of prescription drugs between brand drugs and generic drugs
14 from 2011 to 2014. As you can see, the mix has been
15 steadily increasing, from about 74 percent of prescription
16 drugs in 2011 were generic drug, and this has increased to
17 about 81 percent of prescription drugs in 2014.
18 Because generic drugs are cheaper, increasing the
19 utilization of generic drugs can help keep spending down,
20 and we see that in 2011 to 2013. Spending has remained
21 around $37 to $38 billion, even though if you look at the
22 first column with total drug claims, the number of claims

1 has generally increased. And, so, changing the mix to more
2 prescription drugs -- generic prescription drugs -- has
3 helped keep spending trends low.
4 However, even though the generic mix also
5 increased in 2014, we do see a substantial increase in the
6 total drug spending, and this increase is partly due to the
7 changing mix of drugs being prescribed in terms of, like,
8 the average cost of brand drugs and generic drugs has been
9 going up, as you'll see in this next slide.
10 And, so, this slide shows the average spending
11 per claim by brand and generic status, and as you can see,
12 each year, both the average spending per claim for brand
13 drugs and generic drugs has gone up. And not only that,
14 the rate of change has also increased in each year. And,
15 so, not only is the price going up, but it's going up
16 quicker over this four-year period. And, so, in 2014, we
17 see that brand drugs increased 17 percent and generic drugs
18 increased seven percent in terms of the average spending
19 per claim.
20 One of the things that is driving that 17 percent
21 increase in average spending per claim for brand drugs is
22 the use of high-cost drugs. And here, we're going to

1 define high-cost drugs as being over $1,000 per claim.
2 There are several definitions you can use, so we just kind
3 of picked a standard here.
4 As you can see, the number of claims and the
5 percent of total claims has been increasing over the years.
6 But even with the increase, these drugs that are over
7 $1,000 per claim are still less than one percent of the
8 total number of claims. However, you can see that the
9 gross spending per claim has gone up, and that's reflected
10 in the percent of total spending. In 2011, these drugs
11 accounted for about 20 percent of total spending. In 2014,
12 they were almost a third.
13 And, so, here's a specific example of one class
14 of high-cost drugs that I mentioned earlier, these
15 hepatitis C drugs that have recently come to market. At
16 the end of 2013, the FDA approved Sovaldi for the treatment
17 of hepatitis C, and this drug is incredibly effective. It
18 can cure 90 percent or more of many common types of
19 hepatitis C. But, it also comes with a very high list
20 price. It is about $1,000 a pill, which over the course of
21 treatment is about $84,000 per treatment. Additionally,
22 two new hepatitis C drugs were approved in late 2014 and

1 early 2015, Harvoni and Viekira Pak, and those also have
2 kind of a similar list price.
3 And, so, we see with the introduction of Sovaldi
4 and these other drugs a substantial increase in spending of
5 hepatitis C drugs. Medicaid spent about $1.8 billion for
6 these hepatitis C drugs, compared to about $400 to $600
7 million in the prior three years. In fact, the $1.8
8 billion in 2014 is more than the prior -- all three years
9 combined.
10 We also see that the gross spending per claim has
11 gone up substantially. It's about four times what the
12 gross spending per claim was in the prior three years, and
13 that's a reflection of the high cost of these new drugs.
14 The one thing I should note is this is gross
15 spending and Medicaid does receive substantial rebates.
16 With the introduction of Harvoni and Viekira Pak, many
17 states have mentioned that they've been able to negotiate
18 additional supplemental rebates on these drugs, and some of
19 these supplemental rebates are maybe, like, 20 to 30
20 percent more. So, in 2015, I think if you were trying to
21 get to net spending, you would see that these new rebates
22 would offset some of the spending on these hepatitis C

1 drugs.

2 And, so --

3 CHAIR ROWLAND: Chris, isn't there also --

4 MR. PARK: Yes.

5 CHAIR ROWLAND: -- this is just the drug costs

6 for treatment of this population, obviously.

7 MR. PARK: Right.

8 CHAIR ROWLAND: The earlier, less effective drugs

9 had other costs associated with treatment that, hopefully,

10 the newer drugs don't.

11 MR. PARK: Right. One of the benefits to these

12 drugs, besides providing a cure for hepatitis C, is there

13 are fewer side effects than some of the prior treatments,

14 and so I think there's been a reduction in some of the,

15 maybe, services that are required afterwards.

16 So, the recent spending trends that I've

17 presented today for Medicaid are generally reflective of

18 overall spending trends for prescription drugs that other

19 payers are facing. They're seeing the increase of high-

20 cost specialty drugs that are driving total spending, just

21 as Medicaid has seen.

22 The pricing structure of many of these new

1 specialty drugs, with high up-front costs that can replace
2 or prevent long-term spending on medical services, is
3 particularly a challenge for Medicaid, where you have to
4 pay for these drugs up front within an annual or biannual
5 budget. And, so, it's hard to kind of pay for these drugs
6 while banking on the savings in later years.
7 Also, Medicaid is different from other payers due
8 to the statutory rebates that Medicaid receives. On the
9 plus side, these rebates are substantial, as you've seen,
10 and reduces the net spending that Medicaid has on these
11 drugs -- on all drugs -- much more than other payers can
12 receive. And, so, Medicaid is one of the lowest net payers
13 on drugs once you take into account all these rebates.
14 But in exchange for these rebates, Medicaid must
15 generally cover all prescription drugs from manufacturers
16 that are participating in a program. So, they don't have
17 the option of simply not covering a drug that other payers
18 have.
19 Additionally, there are nominal cost sharing
20 limits in Medicaid and these limits and the enforcement of
21 collecting the copayments really limit Medicaid's ability
22 to change beneficiary behavior that other payers have seen,

1 where they're changing copayments to drive utilization of
2 high-value cost effective drugs.
3 The primary tool that states have to manage
4 utilization of spending is prior authorization, and states
5 have used this prior authorization to different varying
6 degrees. An example of their use of prior authorization of
7 hepatitis C is they've put in pretty stringent requirements
8 in order to get Harvoni, Sovaldi, Viekira Pak. They've
9 required a pretty high level of disease severity. Many
10 states have requirements on abstinence from alcohol or drug
11 use.
12 And, so, there have been a lot of questions as to
13 how far these prior authorization rules can go while still
14 kind of meeting the standard, the coverage standard that is
15 required by the drug rebate program. And, so, I think this
16 challenge is kind of -- will still exist with the
17 introduction of new drugs in the future, and it's kind of
18 not clear where this balance will be found, between
19 utilization management and providing coverage in order to
20 obtain the rebates.
21 CHAIR ROWLAND: Patty?
22 COMMISSIONER GABOW: You can see how eager I am

1 to talk about drugs, but then I come from Colorado.

2 CHAIR ROWLAND: That's true.

3 [Laughter.]

4 COMMISSIONER GABOW: I have four comments. The
5 first one is I think it always seemed to me, maybe
6 incorrectly, that rebates represent one of the more
7 contorted ways to manage drug costs, so maybe a little
8 background about how we got to the construct of paying full
9 price and then getting rebates as opposed to negotiating a
10 -- some history might be useful for that.

11 The second comment relates to every -- it's
12 always said that these rebates are really a good deal for
13 the states, but I'd like to see two tables. And maybe the
14 data is unavailable, but if it were, I'd like to see two
15 tables, one table that is of the 10 highest-cost drugs to
16 the Medicaid program as one; and then the other, the gross
17 cost of that drug to Medicaid, the cost with rebate, the
18 340B cost of that drug, the VA cost of that drug, and then
19 the European Union mean cost of that drug.

20 COMMISSIONER CHECKETT: And the real cost of that
21 drug.

22 [Laughter.]

1 COMMISSIONER GABOW: No, but I think because I
2 suspect -- I obviously don't know this because I've never
3 seen this data -- that there would be easier ways to do
4 this, like Medicaid is only going to pay VA cost, Medicaid
5 is only going to pay 340B prices. But I think it would be
6 very illuminating to have that table.
7 And the second table would be the 10 most
8 commonly used drugs, and 10 isn't the magic number. It
9 could be 15, but some of the top, and then the same panels.
10 I think we might have some very interesting insights into
11 what is the best way to do this.
12 My third comment relates to proposed 340B changes
13 and I think some discussion about what will be the cost to
14 the Medicaid program if there are significant changes in
15 who could use 340B, what organizations can use 340B, the
16 idea that you can't use discharge drugs anymore under 340B.
17 What is that going to drive Medicaid cost up to? I really
18 think that's going to influence the patients, but just
19 talking about the cost piece.
20 And the fourth piece is we know that there is
21 overuse and misuse of drugs, and we sort of got into some
22 of that when we did our paper on psychotropic drugs. And I

1 think putting -- not some analytics in there, but just some
2 comment that what's the estimate of misuse and overuse. We
3 know with antibiotics, it's tremendous, and there's also,
4 obviously, in other circumstances, similar data, so putting
5 that in the mix may give us an idea about the terrain that
6 might be fertile for the future in this area.
7 CHAIR ROWLAND: Other comments?
8 VICE CHAIR GOLD: Really good work. I mean, this
9 is excellent stuff to be doing, especially when we've done
10 other work before that you've published on this, so it's
11 impressive. Keep doing it.
12 MR. PARK: Thank you.
13 CHAIR ROWLAND: I also think that, to pick up on
14 Patty's point a bit, one of the issues here is really going
15 back to psychotropic drugs. To what extent is this
16 spending driven by different populations within the
17 Medicaid program?
18 We know that Medicaid has a very large disability
19 population that is very high utilizers of some of these
20 drugs. It has a lot of individuals with chronic illness,
21 and in this era of talking about Sovaldi and hep C, I think
22 we've kind of lost sight of really who's being covered by

1 the Medicaid program, and so some context of what the
2 highest-volume drugs are, what first is the highest-cost
3 drugs, and to really begin to understand a little more
4 about what we're actually purchasing.
5 MR. PARK: Sure. I can say that Abilify was the
6 highest-spending drug for Medicaid in 2014, about $2.4
7 billion, and Sovaldi was number two at $1.4 billion.
8 CHAIR ROWLAND: The first one is antidepression,
9 right?
10 MR. PARK: Yeah. Abilify is an antipsychotic
11 for, like, bipolar or some depression, schizophrenia.
12 CHAIR ROWLAND: And then the second one was
13 Sovaldi.
14 Donna.
15 COMMISSIONER CHECKETT: A question for you,
16 Chris. I think Diane started to hit on it, too, with
17 looking at not just what costs the most, but what is
18 utilized the most. I think we can tend to make a lot of
19 assumptions about good and bad in this area in particular,
20 like somehow if it's high, it's bad, and if it's low, it's
21 bad. Too much of it, not enough of it.
22 And I wonder, particularly, with generics. I

1 noted that we were at 81.1 percent of what you're saying is
2 generic. Is there ever a sense of that it could be higher,
3 but it's not, or is that like a good place to be? Because
4 it's interesting when you think back when a generic was in
5 the '30s and '40s, it was considered to be good. So I am
6 sensitive to, I think, sometimes we have kind of underlying
7 assumptions of what's good and bad, and in particular, I'm
8 interested in generic. Is that a good place to be right
9 now or not, or do you just not know?
10 MR. PARK: Sure. I think an 80 percent generic
11 rate is pretty high in terms of generic use. I think some
12 studies I've seen for commercial populations and other
13 populations, it can get up to close to 90 percent, but
14 again, they might have a different mix of enrollees.
15 I don't know if 80 percent, 81 percent is a good
16 spot for Medicaid's mix of enrollees, but it is fairly high
17 and kind of typical of what you might see in like the
18 commercial or Medicare world.
19 CHAIR ROWLAND: Andy, did you have a question?
20 [No response.]
21 CHAIR ROWLAND: Steve?
22 COMMISSIONER WALDREN: I was going to say --

1 CHAIR ROWLAND: I'll let Steve go while you
2 think, Andy.
3 COMMISSIONER WALDREN: I was just saying on the
4 generics, you can take the NDC code and roll that up to an
5 RxNorm code, and then you can actually go back and find out
6 which drugs actually do have a generic formulation. So
7 then you would have the denominator being those drugs that
8 do have a generic formulation.
9 Another thing, too, start looking at those top
10 drugs on utilization, you could also go back and say, okay,
11 well, are there alternative classes, so proton pump
12 inhibitors versus H2 blockers and some of those type of
13 things, too, maybe as well. But that's a little bit more
14 challenging because it gets more clinical, but at least you
15 could look at generics.
16 CHAIR ROWLAND: Okay. Andy.
17 COMMISSIONER COHEN: So it seems that one things
18 that's challenging about drug spending, I mean, you can
19 look at the mix, the mix of drugs and whether you're
20 prescribing appropriately and generics, but then the rest
21 of it is kind of like what's your leverage in setting or
22 negotiating prices. And I think we have -- as a country,

1 we sort of have not been very comfortable with the idea of
2 doing -- using purchasing power as robustly as is actually
3 like economically possible in a really big program. And we
4 sort of have to acknowledge that fact. It doesn't mean
5 it's never going to change, but that is sort of the way
6 it's been.

7 But I wondered, the other big purchasers now in
8 the Medicaid program, are managed care organizations that
9 presumably purchase -- and this is a big of a question to
10 those in the room who may know -- who presumably across all
11 business lines do things like purchasing drugs across all
12 business lines, Medicaid, Medicare, whatever they are going
13 to have, if that's really true.

14 So one thing I am wondering is, are changing
15 dynamics, consolidation, et cetera, in the insurance
16 industry likely to sort of change the dynamics of these
17 sort of negotiations and price negotiations over time, and
18 is that a back-door way of more robustly using purchasing
19 power in the program?

20 I know it's not just payers. It's PBMs, and
21 there are multiple players, but there's consolidation in
22 big players. And I wonder if that will potentially have an

1 impact, and I don't know if that's something to encourage,
2 discourage, encourage for purposes of drug pricing and not
3 otherwise, but it's an important trend, I think, to think
4 about what the impact might be on drugs in particular.
5 CHAIR ROWLAND: Chuck.
6 COMMISSIONER CHECKETT: I have sort of a
7 question, just thought you were asking me. You know, I
8 think it's a really interesting question. I'm sure others
9 on the panels have ideas about it, but it actually might be
10 something, I think, for Chris, perhaps for you to dig into
11 is consolidation.
12 I just saw today that I think Walgreens is buying
13 Rite-Aid or something, and so along with the consolidation
14 in the insurance industry and consolidation in PBMs, I
15 think it is a good question to look at how that might
16 continue to drive prices down or not, so --
17 CHAIR ROWLAND: Chuck?
18 COMMISSIONER MILLIGAN: I wanted to pick up on
19 the 340B for a second. Do you have a sense of whether the
20 percentage of drugs that have 340B pricing underneath is
21 growing, shrinking, or level?
22 And I have a follow-up question on that, but I'm

1 curious whether the proportion of drugs that are prescribed
2 by 340B-qualifying entities, FQHCs and others, is changing
3 over time.
4 MR. PARK: Sure. This is kind of a difficult
5 question because the data that we have doesn't include a
6 lot of this information, particularly the data I presented
7 today. A lot of it came from the drug rebate utilization
8 data, and drugs that were purchased under 340B arrangements
9 are not eligible for drug rebates because the 340B price is
10 essentially getting the Medicaid drug rebate up front. And
11 so manufacturers don't have to pay the rebate to the
12 states. Otherwise, this would be kind of double-counting
13 the rebates.
14 And so a lot of the data that we do have,
15 particularly for managed care, comes from the drug rebate
16 utilization data, and 340B drugs should not be included in
17 that information. We could do maybe some work on fee-for-
18 service, pharmacies, spending, and utilization, using the
19 provider identification and MSIS data, but I don't know.
20 There's also complications with that in terms of, even
21 though a provider may be a 340B pharmacy, depending on the
22 arrangement they've set up with the state, there is an

1 option for 340B pharmacy to basically get normal Medicaid
2 payments, because by purchasing a selection of drugs under
3 normal arrangements versus 340B arrangements. And those
4 drugs could be -- would be eligible for rebates.
5 And so we would have to know the specific
6 arrangement at the facility level as to whether they
7 consider themselves a 340B pharmacy in terms of Medicaid
8 rebate purposes, and so it's fairly challenging, I think.
9 CHAIR ROWLAND: So, Chris, talk a little bit
10 about where the Medicaid population gets its care. So
11 these data reflect use of facilities other than like a
12 community health center, which is a 340B?
13 MR. PARK: Well, I think most of the data that we
14 would be seeing, outside of the physician-administered
15 drugs, which would be dispensed in a physician's office,
16 would be from outpatient pharmacies, like retail community
17 pharmacies, like Walgreens, CVS.
18 I think most of the data that we would have would
19 be coming from that, but --
20 CHAIR ROWLAND: But if someone was at Patty's
21 Denver health pharmacy, that wouldn't be included in these
22 data?

1 MR. PARK: Maybe not in the drug rebate
2 utilization data, depending on if they consider themselves
3 a 340B entity for rebate purposes.
4 In the MSIS data, which is the Medicaid
5 Statistical Information System data, which is an accounting
6 of basically all claims on the fee-for-service side, we
7 could maybe match a prescription to the dispensing pharmacy
8 and know if that was like a community health center
9 pharmacy or if it was a CVS.
10 CHAIR ROWLAND: Chuck?
11 COMMISSIONER MILLIGAN: I'm sorry to complicate
12 this a little bit, but an FQHC can have an arrangement with
13 a Walgreens for the Walgreens to be the covered entity by
14 which the FQHC receives its 340B pricing. In other words,
15 FQHCs no longer have to have drug rooms themselves or
16 pharmacies themselves to get 340B pricing, and so you might
17 have a Walgreens that is dispensing drugs that an FQHC
18 physician writes, getting 340B in that same Walgreens,
19 dispensing drugs from an independent physician, not
20 accessing 340B, and a lot of that kind of gets just lost in
21 the wash.
22 MR. PARK: That's correct.

1 COMMISSIONER MILLIGAN: So I think part of - for
2 the larger conversation, part of it is there isn't a lot of
3 visibility into whether the 340B is getting maximized or
4 not, and part of it is if Walgreens -- just to use
5 Walgreens as an example because it's a common example in
6 New Mexico -- that Walgreens, what its ingredient
7 purchasing price is if some of them are FQHC, all of that
8 stuff.
9 And I guess I would want to just leave a little
10 anecdote, which is former Tennessee Governor Phil Bredesen
11 in his State of the Union -- State of the State, maybe 10
12 years ago, had one data point on Claritin, when Claritin
13 was like the drug everybody was talking about, that the
14 state was spending more on -- the state Medicaid program
15 was spending more on Claritin than it was contributing to
16 the University of Tennessee Medical School as an
17 appropriation.
18 So this is a theme that's been going on a while,
19 and a lot of it relates to kind patent issues. But I do
20 think that a lot of the tools and a lot of the underlying
21 issues are part of the legacy Medicaid too.
22 CHAIR ROWLAND: Other comments? What more would

1 we like Chris to be doing? Tables, those two tables with
2 the prices. I think -- oh, Marsha. You have some ideas for
3 Chris?
4 VICE CHAIR GOLD: Well, the one thing -- yeah. I
5 think what's important as you're looking at some of these
6 things, if you can figure out whether there's any
7 opportunity to look at things that are -- to figure out
8 where there are problems in some of these trends and
9 whether there's any policy, any things, any ways that you
10 can look at area, like if hepatitis C was a big driver of
11 the cost increases, is there offsetting costs and other
12 things or are there other ways to do it. I don't know this
13 area enough to know what to look at, but it seems like this
14 is all interesting in itself. But if you come across
15 things that you think are really policy relevant, you might
16 be looking at that and figuring out what you can be doing
17 to bring back to us that might be useful to look at more
18 broadly, where the problems are and are there any solutions
19 that we might be thinking about.
20 CHAIR ROWLAND: Andy?
21 COMMISSIONER COHEN: Just a thought along the
22 lines of what Marsha was saying. My personal sense is

1 that, again, tackling head on the question of pricing, the
2 actual level of pricing, is challenging to have an impact
3 on that from there. But, certainly, the methodology for
4 doing the rebates is so unbelievably sort of complicated,
5 obscure. It actually distorts a lot of other behavior.
6 Every day, there is an OIG or some other sort of
7 investigation about manipulation of drug pricing that's
8 related to just how difficult and obscure and complicated
9 the methodologies are.
10 So, I mean, I wonder if there is some value in
11 just looking more at sort of trying to think of ways to
12 enhance the sort of transparency and simplicity of the
13 pricing approach from the federal government, so that even
14 if -- you know, the question of levels is really a very, I
15 think at this point, sort of political question, but the
16 question of how the calculations go and how transparent it
17 is and how simple it is might be something where we could
18 at least make some suggestions on how to sort of clean up
19 what has become increasingly -- I mean, just an incredibly
20 complicated area. It's so complicated that people -- it's
21 almost impossible to jump in just because it is so
22 complicated.

1 CHAIR ROWLAND: Well, clearly one other area
2 where I think we need to begin to do some background work
3 and think about is what we've seen in all the hep C drugs,
4 but we know there are other blockbuster drugs about to come
5 on to the market. Are the ways that Medicaid currently
6 reimburses and finances and adopts these drugs sufficient,
7 or do we really need to look at other strategies for how to
8 address some of these changes that are going on in the
9 marketplace?
10 And second, personally, I would be interested in
11 knowing what difference the provisions that allowed managed
12 care plans to take advantage of the rebates have made. Was
13 this a good change? How did it affect it? Because I think
14 we are going to be in a situation where they are looking
15 now in the Medicare program at are there better ways to
16 manage their drug costs, and Medicare private insurance,
17 I'm sure is considering what to do about some of these
18 other new drugs coming on board. And Medicaid is kind of
19 the one place that, along with 340B, there has been some
20 government regulation or negotiation. So what can we say
21 about this, and how can we look at some of the issues and
22 challenges going forward in the future?

1 Okay. Well, thank you, Chris.
2 I'm going to call this afternoon -- if I had to
3 do a graphic for Patty, I was going to put a big box, a big
4 tool box out there, and say we've been trying to put tools
5 into this box all afternoon. But now we're going to turn
6 back to DSH and data, which is not part of our tool box.
7 And we're going to make Jim and Rob come back up
8 once again.
9 And, so, this morning, we went through the report
10 to Congress that we are in the process of preparing on
11 disproportionate share hospital payments. We made many
12 suggestions to our incredible staff about how we would like
13 to have that sharpened, refocused, but basically approved
14 the content and the material in what I believe is a very
15 excellent report to the Congress that we will be preparing
16 for delivery to the Congress as specified by the statute on
17 February 1, and then including that report and its analysis
18 as part of our March report to the Congress so that we
19 ensure that it endures forever in the records of MACPAC
20 reports.
21 But, meanwhile, we had talked this morning about
22 a potential recommendation that we wanted to include in the

1 report, and we have discussed that in the morning but we
2 were coming back now to see if we can come to some final
3 language about that recommendation and then actually vote
4 on it so that our report authors have the advantage of
5 having a recorded vote on whether or not we're going
6 forward with that recommendation.
7 So, with that, I turn it back over to Jim and
8 Rob.
9 **### Review of Recommendation on Medicaid**
10 **Disproportionate Share Hospital Payment Policy**
11 * MR. TEISL: Thank you. So, after this morning,
12 we thought more about the wording of the proposed
13 recommendation and specifically the recommendation for data
14 on all types of Medicaid payments. As we discussed this
15 morning and in previous sessions, Medicaid's shortfall is a
16 component of uncompensated care for Medicaid DSH, and a
17 full understanding of Medicaid payment and, thus, Medicaid
18 shortfall really does require that we have timely data on
19 all of the Medicaid payments that all of the providers
20 receive--I should say hospitals--for the purposes of DSH
21 analyses.
22 So, based on that, we sort of stuck with the

1 language that we had this morning, although we did take out
2 the parenthetical acronym "HHS" after Health and Human
3 Services. But, we did stick with the recommendation for
4 hospital-specific data on all types of Medicaid payments
5 for all hospitals that receive them.

6 We also talked about the fact that in the
7 rationale, we can discuss in more detail the specific types
8 of payments that this would include, as well as be a little
9 more specific about our need for these data, both for
10 analyses of current DSH policy and the development of
11 potential future DSH policies, including, for example,
12 better targeting of DSH allotments to states and payments
13 to providers.

14 CHAIR ROWLAND: Comments? Andy.

15 COMMISSIONER COHEN: I just want to say, I
16 strongly support the change that was made.

17 [Laughter.]

18 COMMISSIONER RILEY: I think it enhances the
19 recommendation quite a bit, and I want to say, having been
20 the person who was concerned about using all types and
21 having spent an hour really trying to come up with an
22 alternative that was a bit more precise but comprehensive,

1 I couldn't, and I think--and I agree that Jim and Rob's
2 formulation is appropriate, and having some more connection
3 in the rationale to the specific needs will satisfy me.
4 So, I will support the recommendation.
5 CHAIR ROWLAND: Any additional comments?
6 [No response.]
7 CHAIR ROWLAND: Okay. Then, Jim, I would ask you
8 to read the recommendation into the record and then we will
9 take a vote on it, if someone would like to recommend that
10 we adopt the recommendation after Jim reads it.
11 MR. TEISL: So, the recommendation is, the
12 Secretary of the U.S. Department of Health and Human
13 Services should collect and report hospital-specific data
14 on all types of Medicaid payments for all hospitals that
15 receive them. In addition, the Secretary should collect
16 and report data on the sources of non-federal share
17 necessary to determine net Medicaid payment at the provider
18 level.
19 COMMISSIONER COHEN: So moved.
20 CHAIR ROWLAND: Okay. Anne will take the roll
21 call.
22 EXECUTIVE DIRECTOR SCHWARTZ: Sharon Carte.

1 COMMISSIONER CARTE: Yes.

2 EXECUTIVE DIRECTOR SCHWARTZ: Donna Checkett.

3 COMMISSIONER CHECKETT: Yes.

4 EXECUTIVE DIRECTOR SCHWARTZ: Andrea Cohen.

5 COMMISSIONER COHEN: Yes.

6 EXECUTIVE DIRECTOR SCHWARTZ: Gustavo Cruz.

7 COMMISSIONER CRUZ: Yes.

8 EXECUTIVE DIRECTOR SCHWARTZ: Patricia Gabow.

9 COMMISSIONER GABOW: Yes.

10 EXECUTIVE DIRECTOR SCHWARTZ: Marsha Gold.

11 VICE CHAIR GOLD: Yes.

12 EXECUTIVE DIRECTOR SCHWARTZ: Herman Gray.

13 CHAIR ROWLAND: I would note for the record that

14 Herman is not present but did say that he supported the

15 recommendation in a proxy e-mail to us.

16 EXECUTIVE DIRECTOR SCHWARTZ: Mark Hoyt.

17 COMMISSIONER HOYT: Yes.

18 EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan.

19 COMMISSIONER MILLIGAN: Yes.

20 EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin.

21 COMMISSIONER RETCHIN: Yes.

22 EXECUTIVE DIRECTOR SCHWARTZ: Trish Riley.

1 COMMISSIONER RILEY: Yes.

2 EXECUTIVE DIRECTOR SCHWARTZ: Norma Martínez

3 Rogers.

4 COMMISSIONER MARTÍNEZ ROGERS: Yes.

5 EXECUTIVE DIRECTOR SCHWARTZ: Sara Rosenbaum.

6 CHAIR ROWLAND: I would indicate for the record

7 that Sara Rosenbaum is not present but was in support of

8 this recommendation, confirmed in an e-mail.

9 EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi.

10 COMMISSIONER SZILAGYI: Yes.

11 EXECUTIVE DIRECTOR SCHWARTZ: Steve Waldren.

12 COMMISSIONER WALDREN: Yes.

13 EXECUTIVE DIRECTOR SCHWARTZ: Diane Rowland.

14 CHAIR ROWLAND: Yes.

15 EXECUTIVE DIRECTOR SCHWARTZ: Okay. So that's 14

16 yeses and two not present but expressed support in writing

17 that we will attach to this. Okay. So, I guess that's a

18 recommendation.

19 CHAIR ROWLAND: The recommendation is approved,

20 and in conclusion, I would again want to compliment the

21 work that has gone into this report and all the issues that

22 you've laid out here just mean lots more work going

1 forward, because this is such a critical issue and it
2 really is one where the policy has got to be moved in a
3 broader and different direction and a more focused
4 direction. We really do have to take account of the fact
5 that the ACA is being implemented. It has changed the
6 groundwork and we need to really be able to build on the
7 work you've already given us to continue this as a high
8 priority for the work of MACPAC. So, thank you very much.
9 And, now we'll turn to any comments from any of
10 the individuals who have joined us in the audience.
11 [Pause.]
12 CHAIR ROWLAND: Would anyone like to make a
13 comment?
14 ### **Public Comment**
15 * [No response.]
16 CHAIR ROWLAND: Well, seeing that the microphone
17 is still empty, I thank those who have joined us today for
18 this meeting, and at this point, the MACPAC meeting is
19 adjourned.
20 [Whereupon, at 3:38 p.m., the proceedings were
21 adjourned.]