PUBLIC MEETING

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

Thursday, March 31, 2016
10:04 a.m.

COMMISSIONERS PRESENT:

SARA ROSENBAUM, JD, Chair
MARSHA GOLD, ScD, Vice Chair
BRIAN BURWELL
SHARON L. CARTE, MHS
ANDREA COHEN, JD
GUSTAVO CRUZ, DMD, MPH
TOBY DOUGLAS, MPP, MPH
HERMAN GRAY, MD, MBA
LEANNA GEORGE
CHRISTOPHER GORTON, MD, MHSA
STACEY LAMPKIN, FSA, MAAA, MPA
NORMA MARTÍNEZ ROGERS, PhD, RN, FAAN
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
PETER SZILAGYI, MD, MPH
PENNY THOMPSON, MPA
ALAN WEIL, JD, MPP

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[10:04 a.m.]

CHAIR ROSENBAUM: Good morning, everybody. Welcome to our March-April MACPAC meeting. We have a very full agenda. We welcome you all. We are going to have a full day today with a comment period, of course, a public comment period at the end of this morning and then at the end of this afternoon. And then we meet again tomorrow morning in public.

Let me just take one minute and update you all on the issue of development of the conflict of interest standard. So we have already begun work on our disclosure and conflict of interest policy. It is our plan to bring to the May meeting our working version of the conflict of interest policy so that we can have public discussion, vote on it, and get it posted to our website and start operating under it as soon thereafter as humanly possible.

So that's the schedule on disclosure and conflict of interest. Because the work has begun but it obviously

takes a bit of time to develop such a policy, we won't be discussing it today, but there will be considerable time on the May agenda for this issue.

So I'm going to turn it over to Anne for our day.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. I just want to share the plan for the June report, four chapters of which will be reviewed today. The three chapters that are going to be presented this morning are part of a section of the report that will be packaged together, and just to share sort of what the thinking is about how they fit together, which will be reflected in an introduction to the section in this report.

Chris is in a moment going to talk about Medicaid spending trends. This is information that he and others have shared over several months, looking at spending in the program through a variety of lenses. And then the two chapters that follow, as Martha and Moira will share when they come up to the mic, talk about the kinds of changes to financing that are being discussed in Congress that would put limits on federal spending, and the chapter talks about the design issues in that. And then the subsequent chapter talks about to the extent that states would face limits on

federal spending, what are the actions that might be anticipated under current law and what might be requested in terms of authorities for states to be able to live within those limits?

So that's the Gestalt of these three chapters, and then I'll just turn it over to Chris to start the presentation.

REVIEW OF DRAFT CHAPTER FOR JUNE REPORT: MEDICAID SPENDING TRENDS

* MR. PARK: Sure. Thanks, Anne.

As Anne mentioned, this session will review our draft chapter on Medicaid spending trends for the June report. It's largely data and information that was presented in the May and September meetings last year. So for the Commissioners who were present at that time, it'll be a refresher on that information with a few updates to more recent data where that's available.

During today's session, I'll be looking at Medicaid spending trends in the context of national health care spending and federal and state budgets. I will also discuss the components of spending growth, which include changes in enrollment and changes in spending per enrollee.

And then I'll also present some data on recent changes in Medicaid spending and projections for future years and, in particular, highlight some of the areas where the eligibility expansion to the new adult group had a part.

So this table shows the share of national health expenditures by various payers, and Medicaid's share of national health expenditures has grown over time, from about 10 percent in 1975 to about 16 percent, as shown in the circle highlighted here in 2014. Even with the growth, Medicaid is still a smaller share of national health expenditures than either Medicare, which is about 20 percent, or private insurance, which is about 33 percent.

For certain types of services, particularly long-term services and supports, Medicaid is the largest payer for these services, and that reflects Medicaid's unique role in providing LTSS. Medicaid financed almost one-third of nursing facility care and over half of the category of other health, residential, and personal care services, and this bucket includes a lot of the home and community-based services under LTSS.

Looking at projections of national health expenditures, we see that Medicaid is projected to grow to

about 17 percent in 2015, and this is still less than Medicare or private insurance. Going forward to 2024, Medicaid will decrease slightly to about 16.4 percent, while Medicare will increase to about 23 percent and private insurance will decrease slightly to about 32 percent.

This slide shows the major components of total federal outlays from 1965 to 2015, so from when Medicare and Medicaid were first introduced. Looking at this, we see mandatory programs have increased substantially over this time period, going from about 30 percent of federal outlays to about 60 percent, and this is largely due to the increase in spending for the health care-related programs such as Medicare, Medicaid, CHIP, and the exchange subsidies.

Medicaid was about 9.5 percent of federal outlays in fiscal year 2015 compared to Medicare, which was about 14.6 percent.

Since 2000, Medicaid has grown at a slightly faster rate than Medicare, with Medicaid growing at an average annual rate of 7.5 percent and Medicare growing at 7.1 percent. Over the next five years, both CBO and OMB

projections show Medicaid growing slightly less than Medicare over that period.

In addition, you know, with the states' share of Medicaid spending, Medicaid’s share of state budgets, including and excluding federal funds, has grown over time, and the reason why we're showing these different lines is that how you measure Medicaid's portion of a state budget depends on whether you include federal funds or not. So if you include federal funds, Medicaid was about 25 percent of the overall state budget. And if you exclude federal funds, just looking at the portion that states have to raise on their own through taxes and other funding means, if you look just at the general funds that the states use, it's about 19 percent. And if you include other sources of funding, including for Medicaid, health care-related provider taxes, and also local funds from local governments, then Medicaid is about 15 percent.

So, you know, when we see various statistics, it's important to kind of think about whether this includes the federal funds or just the state-funded portion of the budget.

This information is essentially the same as the

slide before, showing Medicaid portion of both total state budgets and state-funded budgets, but it also includes some comparisons to both elementary and secondary education and higher education. And, again, we show both the total state budget, including federal funds, and state-funded budget where we exclude federal funds. And we can see that because Medicaid receives a greater portion of their total budget from federal funds, that if we include the total state budget with the federal funds, Medicaid is the most significant piece. It's about a quarter, where elementary education is around 20 percent and higher education is around 10 percent. But if we just look at the state-funded portion, then elementary and secondary education is the highest portion of the state budget at 24 percent, followed by Medicaid and higher education.

This table shows the average annual growth in Medicaid spending per enrollee compared to various benchmarks, and we're looking at spending per enrollee to kind of remove some of the increases in spending due to enrollment. And so this gets to some of the issues of how much is due to price inflation, changes in volume and service mix, and also changes in the enrollment mix.

As you can see, since the early 1990s, annual growth in Medicaid spending has been lower than or comparable to Medicare, private insurance, and also medical price inflation as measured by the CPI-U, the medical component of the CPI-U, which is the Consumer Price Index, the Urban Consumer Price Index.

I also want to highlight two time periods in particular where we see Medicaid spending per enrollee decreasing over time in that particular one-year period. So between 2005 and 2006, we see Medicaid spending per enrollee decrease and Medicare spending per enrollee increase substantially, and this is due to the implementation of Part D where drug spending for dually eligible individuals who have both Medicaid and Medicare coverage, that spending shifted from Medicaid to Medicare.

In 2013 to 2014, Medicaid spending per enrollee decreases, and this is a function of the new adult group coming in. These were lower-cost individuals than -- like the disabled or the aged eligibility groups. So we have a higher proportion of lower-cost individuals, which brings down the average spending per enrollee for the entire Medicaid program.

Going forward to 2023, we see that Medicaid spending per enrollee is projected to increase over historical periods, but this is still lower than Medicare, private insurance, and also price inflation, which is around 4 percent.

The next few slides touch on the components of spending growth, and Medicaid spending is comprised of the number of enrollees multiplied by the average spending per enrollee. And the things that can change and increase the number of enrollees include things like eligibility expansions, economic downturns, and the aging of the population as people become eligible for Medicare coverage when they turn 65 or when they start needing long-term services and supports.

Spending per enrollee can be driven by the enrollment mix between types of individuals and their underlying health conditions, the volume and mix of services used, and the prices paid for items and services.

This slide shows the components of spending growth in real Medicaid benefit spending, and what we mean by "real Medicaid benefit spending" is that it has been adjusted for inflation over time. And so as we can see in

this slide, most of the growth in Medicaid spending from 1975 to 2010 has been attributable to an increase in the number of enrollees. About 70 percent was due to number of enrollees and about 30 percent was due to changes in spending per enrollee. And as this is inflation-adjusted, the spending per enrollee largely reflects changes in enrollment mix as well as the increase in the intensity and volume of services.

This next chart shows the average annual growth rates in Medicaid enrollment and spending from 1975 to 2014. What we've highlighted here with the gray bars is some particular periods of change, and as you can see, over time spending and enrollment generally has that nice relationship where, when enrollment increases, spending also increases, as we were mentioning in the previous slide.

As you can see, during certain times of either eligibility expansions or recessions, enrollment and spending both tend to increase. And then there are a couple of policy changes in eligibility that we've highlighted with the Omnibus Reconciliation Act of 1981 and welfare reform in the mid-1990s that effectively reduced

enrollment.

This chart is essentially the same chart that we saw two slides prior showing the components of growth due to number of enrollees and spending per enrollee. But what we've done here is shown the contribution to each of these pieces due to the different eligibility groups. And so the blue dotted slices are due to the growth in number of enrollees, and the green solid slices are due to the growth in spending per enrollee.

One thing we see here is that the disabled eligibility group, these individuals contributed almost half of the spending growth over time. If you add up the growth due to spending per enrollee for the disabled and the growth due to the number of enrollees for the disabled group, that's just over 50 percent. And this isn't because there is, you know, explosive growth in the disabled eligibility group. It's because these individuals cost a substantial amount on average. On this chart, you can see that the disabled population on average was about $18,000 per enrollee compared to children at about $2,600 and adults at $4,000. So if you add one average disabled eligibility group enrollee, that's going to add more

spending than if you added five average children. And so this demonstrates how important the enrollee mix is when you're calculating the average overall spending per enrollee for the Medicaid population.

And while not shown in this chart, the new adult group is a little bit lower cost than either the disabled or aged eligibility groups. So the expansion to the new adult group does have that effect of driving down the overall spending per enrollee for the Medicaid population. The CMS actuaries estimated that the overall spending per enrollee increased about 0.3 percent from 2013 to 2014. But if you excluded the changes in enrollment mix, the estimated increase would have been about 3.1 percent.

The other thing this slide shows is that the service mix and the intensity of services and how much they spent on particular service categories does differ between the eligibility groups. As you can see, LTSS spending for the disabled and aged eligibility groups contribute a lot to the spending over time. The LTSS users were about 6 percent of enrollees, but they accounted for 40 percent of spending.

I'll just briefly touch on this because prices do

play a part in spending per enrollee, but Moira and Martha will talk about this a little bit more in their session later.

So prices can be set by states, and they have some flexibility in setting provider payment rates. The way they set provider payment rates may not track with underlying growth in health care prices as they have different -- you know, they're looking at different things in terms of either maybe increasing access or tight state budgets. They also may be influenced by mechanisms for financing the state share, financing sources such as health care-related provider taxes.

In 2014, Medicaid spending increased 8 percent from 2013 to 2014, largely due to the increase in enrollment through the expansion to the new adult group. Federal spending increased 13 percent while state spending increased 1 percent, and this is due to the 100 percent match for the new adult group.

In addition, besides the eligibility expansion, other factors also were accounted for, including the primary care bump that was in place for 2013 and 2014, and high-cost drugs also contributed to spending growth in

2014.

Going forward, for 2015 and beyond, CMS actuaries are expecting slower growth at about 6 percent average annual growth going forward, and this reflects moderation of the expansion effects as the new adult group enrollment kind of tails off after the initial increase in enrollment, expiration of the primary care bump in 2015, and also an increase in drug rebates going forward.

Of course, the growth in Medicaid spending does differ by type of service, and we see here in 2013 and 2014, over 20 percent growth in the physician and clinical services line and also the prescription drug line, and this reflects both the enrollment increase within the adult group as well as things that I mentioned previously about the PCP bump and also the introduction of high-cost drugs, particularly the hepatitis C drugs in 2014, Sovaldi and Harvoni.

Another thing that I'd like to point out is because this -- you know, a lot of the spending increase in categories is related to the enrollment increase with the new adult group. So if we look at types of services where the new adult group is expected to use fewer services, such

as nursing and retirement facilities, home health, and the other health, residential, and personal care, we do see that the spending increase in 2014 was lower than the other services.

In going forward, this slide shows the average annual growth rate and projected enrollment and spending per enrollee by the different eligibility groups, and enrollment is expected to increase about 2 percent of this period. And as you can see, most of this enrollment will be driven by the new adult group. They're expected to grow at about 12.1 percent of this time period where other groups are around 3 percent or less, and much of this enrollment growth for the new adult group is going to be in the first couple of years, as states implement the expansion.

Additionally, spending per enrollee, for most eligibility groups, is expected to increase right around or a little bit above the medical inflation rate of 4 percent.

I'd like to point out that the decrease in spending per enrollee for the new adult group reflects that the CMS actuaries expect a healthier mix of individuals to be enrolled during the later years, as the new enrollees

typically have a lot of -- the sicker enrollees enroll early, and they also have some pent-up demand that they require greater use of services in the early years.

So this concludes my presentation, and we would appreciate any comments the Commission has on the chapters, information presented today.

CHAIR ROSENBAUM: Thank you, Chris. That was excellent.

Marsha, why don't you lead us off.

VICE CHAIR GOLD: Okay. Thanks.

I gave some written comments with details to the staff, but I'll just talk about some of the main points here. I think the staff has done a great job of pulling together an awful lot of numbers and facts and all the rest. What I think would be really helpful is to sort of shift from describing some tables to a little more analysis of what it means, and the reason for that is that presumably -- and we'll talk about this in the next session -- this will be a three-chapter block that responds to Congress' concern about rising costs and whether there are changes in financing that should fix is.

Well, then it seems to me this is really a

foundational chapter that needs to look at the premise and describe it. Are costs rising, and how do we understand them? And what can we understand about the causes, so that as we look at some of these things, we see what effect they might have on costs?

And I'm not sure that the facts have been pulled together as much as they might be to sort of help guide us through that process. I'll throw out a couple of ways that one might summarize it. This isn't the only way, and I think staff will check what's right with the facts in there.

But it seems that the logic of it -- and I would hope we could present that in the overview of the chapter so that people don't have to guess what the numbers mean, but we tell them what we think they mean from our analysis of them -- is that Medicaid is an important cost of both federal and state spending, though in the federal context, it may not be the largest insurance program. It is a large one, so it's important. Costs have been going up, so that's important.

A lot of it then -- I think when you say a lot of it is based on enrollment -- and that needs to come up

front that it's enrollment that has driven a lot of it, which is a mixture of sort of demographics, the given program rules, and explicit policy changes that have driven enrollment. And so it's gone up. It's because of that.

And then the costs per enrollee, I think we probably need to build a mix in so it's clear that it may be a little understated how much. But, in fact, I think it looks like states have done a reasonable job maybe in recent years of trying to keep things down within constraints. I don't know how far that can go, but that also, though, a lot of it is connected with things that aren't Medicaid-specific, and so there's other players because the rates have been sort of similar to other places. So there's issues of how to handle it.

So I'm not sure that's exactly right, but I'm thinking that we need sort of four or five major themes that pull these numbers together and tell a story that hopefully then, as the other chapters are laid out, can respond to -- can build on that theme, and probably, they'll need to take the -- they will need to be worked together more for obvious reasons. Everyone is working on these chapters a little separately, but hopefully, then

they can be cohesive. And that was my sense.

CHAIR ROSENBAUM: Thank you. We actually had -- go right ahead, Chuck.

COMMISSIONER MILLIGAN: Thanks. Chris, good work. I'm going to, I think, ask several things and several comments and try to tie it back to some of the slides.

Slide 8, if we can maybe go there, and then I'll sort of move on to more of the substantive comments.

I think that it's not going to be -- so I am looking at the upper right kind of part of this pie on the left-hand side. 10.7 percent, state; 14.9 percent, federal. I think for people who think that the federal government is picking up at least half the match rate, this is going to seem like an odd ratio. And I think it needs to just be explained because I think that there are ways in which the federal dollars can be -- if they're included, they're in then the denominator and numerator and all those kinds of things, but I think that people will wonder how it can be that the state and federal financing is relatively close if the federal government is paying at least double the state.

And if you want to comment on that now, I have other things I want to make sure to get to as well.

MR. PARK: Yeah. So I think, historically, the federal government share of Medicaid spending has been about 57 percent, and I think that looking at the math right here, it's roughly what is being shown there.

COMMISSIONER MILLIGAN: Okay.

MR. PARK: In 2014, due to the increased spending on the new adult group at 100 percent, it's now up to about 60 percent.

COMMISSIONER MILLIGAN: Just give a little of that context when you present this down the road.

MR. PARK: Okay.

COMMISSIONER MILLIGAN: Is this data coming mainly from claims-based information?

MR. PARK: This slide in particular --

COMMISSIONER MILLIGAN: The presentation as a whole.

MR. PARK: Oh, sure. It's coming from a variety of sources. Some of it comes from the CMS office of the actuaries and their projection of national health expenditures by different payers, CBO projections. This

particular slide comes from information from the National Association of State Budget Officers.

COMMISSIONER MILLIGAN: So maybe I'll make the point and then move on. I think what's missing in the context when we talk about the drivers of spending is all of the policy-driven Medicaid expenditures that are not necessarily tied directly to a beneficiary. It may be DHS. It may be GME. It may be IME. It may be other things that I think contextually are a part of spending. That we need to make it clear that not every dollar spent is tied to a service for a member.

And I think that when you describe the Part D, the claw-back piece kind of gets lost in that discussion. I think it needs to be part of that discussion, and if you're looking only at claims, you're going to miss the claw-back. So I think the broader finance, the broad state expenditures -- and I would include in that, by the way, spending for people who aren't receiving full Medicaid benefits, and that could include things like emergency Medicaid for people who are undocumented at hospitals. It can include things like QMB, SLMB. It can include a lot of pieces, but I think all of the other policy-driven

expenditures for people who don't have a Medicaid card for full Medicaid benefits, that context from a spending point of view is going to be just to have -- not to dwell on it, but to make sure it's not missing.

Slide 9. I think it's important to note that when we look at Medicaid, Medicare, and private insurance different trends, all of these product lines have many moving parts underneath them. A lot of the Medicare growth over the next decade is going to be really demographic-driven. There's a lot of baby boomers aging into Medicare. That enrollment growth is going to be significant.

Within employer-sponsored insurance, there's a lot of changes in benefit design. I think that a lot of the growth with CHIP, the growth with Medicaid of higher income levels has also changed the mix of people who are served through employer-sponsored insurance. There are maybe fewer children in employer insurance and more employees and adults, because the kids might be in Medicaid or CHIP over the arc of this time frame.

So I think you just need to contextualize that none of these are static. Medicaid isn't, but certainly, the other programs aren't as well. A lot more employee

cost sharing, a lot more defined contribution models, all that kind of stuff, I think that context, just a few sentences when you get to the chapter, will matter because all of these are fluid.

And I guess I'll wrap up with one last comment about Slide 11. In spending per enrollee, you talk about enrollment mix. You talk about volume and mix of services and price, and maybe embedded in the volume and mix is the change in benefits themselves, the growth in HCBS, the growth in a lot of other sources. In other words, new benefits have come online. It's not just intensity, like how many visits or how many prescriptions, and it's not just mix like outpatient versus inpatient. But the benefit design to including more HCBS, including more and more mental health and behavioral health services, I think that is a component in the spending per enrollee that was a little bit glossed over when we look at just the volume and intensity.

So I'll leave it there. Thank you.

CHAIR ROSENBAUM: Thank you. Penny.

COMMISSIONER THOMPSON: First of all, I want to agree with both Marsha and Chuck in a number of their

comments and also in complimenting you on the chapter.

I was eager for some more decomposition of the spending. One is that I often find when we talk about kind of spending nationally, it's very interesting to kind of see where the program at large is going, but I was very interested in it. Maybe it's picking up on something both Marsha and Chuck said, which is I was interested in, how has managed care changed spending? How has the move to adoption of more home- and community-based services changed spending? And do we see different patterns in this spending in different kinds of states, either individual states or groups of states that might have similar kinds of characteristics in terms of their program structure or approach?

I think, again, when we get to some of the later chapters and we're talking about what kinds of incentive there are in the program and what kind of levers can promote efficiency, some of that further decomposition can help us understand where we can really move the needle and where we really have already moved the needle to a certain place or what kind of opportunities might really be there for us.

CHAIR ROSENBAUM: Toby.

COMMISSIONER DOUGLAS: Great work by Chris. It's really, really good, and I'd just agree with Marsha and Chuck and Penny's comments.

On Marsha's summary at the beginning, which was really, really good and I agree with, the one piece that I would add and it kind of fits into what Chuck and Penny are pointing out would be that when we look at the spending per enrollee, it's the disabled. It's the aged population. That's where the main driver is, which then dovetails into exactly on, okay, well, how does that play out in this changing world of managed care? How does that play out in this change role of home- and community-based and long-term care services? Because the premise we need to get, if you're going to really tackle, putting aside enrollment, unless you're going to cut enrollment, you're going to need to deal with the disabled population cost, and we need to better understand what have been the ways that that has changed over time.

CHAIR ROSENBAUM: Brian.

COMMISSIONER BURWELL: Kind of along the same lines, I mean, I see this as an educational product, and so

one thing I think should be added is just a very simple distribution of expenditures by major eligibility groups. Where is the money going for aged, disabled, children, and adults? It's a little bit in the cost per enrollee, but just a simple explanation of where the expenditures are going.

Obviously, a challenge here is how much depth to get into in terms of telling the story about Medicaid because it's a very complex story.

So, in LTSS, there's been a lot of changes in the story. In order to address kind of the concept that this is a program that's just out of control is actually a good story to tell on LTSS with a shift to home- and community-based services and the cost per LTSS recipient going down over time as that shift has occurred.

I don't know if you really have the space and time to get into that story, but I think it's an important part of the overall spending trends.

CHAIR ROSENBAUM: Alan, then Kit.

COMMISSIONER WEIL: I certainly align myself with both the good work in the chapter and the sense that there's always more that could be said about the topic.

Having spent a lot of time trying to communicate and understand how to communicate this complex topic, I have a reaction to sort of some of the early comments about telling the bigger picture story. But I'll start with a small point, which is when you talk about eligibility growth, you talk about sort of demographic factors, and you talk about changes in eligibility. There is a third factor, which is take-up among eligibles, and I think that's lost and particularly given the effort that's been made to increase those rates.

But it really comes back to, I think, a tension in the chapter both with respect to data and presentation, which is we could ask you -- and I just did -- to keep adding factors. You know, there's recessions. There's limited benefits for emergency care, and commercial benefits are changing, and Medicare demographics are changing. You just expand the list of factors. I think that's helpful because it reminds people of the complexity.

The question is, where can you go beyond factors to reasons, this share of this change is attributable to this? And a lot of that work does not derive from these same data sources, which gets back I think a little bit to

Penny's comment, which is that there's been a lot of analytic work at a specific state level or in a specific service area or a specific time period to try to decompose that you can't then generalize to the whole system, but because the data at the system level would mask those kinds of things.

And so I think the question is maybe -- again, always risking overloading one chapter -- where is it possible to go deeper by drawing on other types of analysis that, for example -- you've got this nice -- I'll just use a specific example, but you could do it in other places.

Slide 13, you've got these shaded periods of different growth rates, some of which are due to external factors like a recession, some of which are due to eligibility changes like the expansions in the '80s and the expansions in the ACA. Well, to actually decompose, what share of the growth is due to policy change as opposed to what share of the growth is due to broader demographic shifts? That's a different kind of analytic project. It's not something you're going to be able to do with these data, but that other people have tried to do.

So I just think that there may be key subtopics

within the chapter where you could reach out to other kinds of analysis to try to go and layer it deeper in the story. If you try to do that with everything, this becomes a book, but if you do it in a few key areas, I think it could be good.

EXECUTIVE DIRECTOR SCHWARTZ: And, Alan, do you think that that could be accomplished effectively by using some boxes to do sort of a sidebar, or do you think that it needs to be part of the narrative of the chapter?

COMMISSIONER WEIL: I'm always for boxes. My challenge with boxes is that they're often used for sort of vignettes, you know, "Look how State X managed to have four consecutive years of no cost growth."

EXECUTIVE DIRECTOR SCHWARTZ: Right.

COMMISSIONER WEIL: That's really interesting: no per-capita cost growth. I guess I was thinking of something different, which is the blending in of the analyses that have attempted to decompose either, as they say, a shorter time period or a particular service mix or particular eligibility group. And I'm not sure that's so much a box as --

EXECUTIVE DIRECTOR SCHWARTZ: As an elaboration

of that point. Okay.

CHAIR ROSENBAUM: Kit.

COMMISSIONER GORTON: So, Chris, following this theme of decomposition and sort of outlining the factors, I think when you start, if the goal is to create over the course of these three chapters an actionable framework, which we can then use to make recommendations to help policymakers figure out what to do next -- and I get the part of it is do we think there's a problem or not, and while I think that the Commission can take a point of view in terms of if you look at all these numbers, maybe there isn't a problem, on the other hand, I've never met a state budget officer yet who didn't think there was a problem, including what we've seen from Energy and Commerce, is they're listening to the state budget officers, with good reason. So I think that perspective has to be taken seriously, and in the reality of the state capitals, you have to understand that this feels like a problem, even if the data at a national aggregate level don't feel as problematic.

So I do think we need to be looking at -- we've got folks who want to do something, and we need to inform

an action agenda. So, in order to address trends, I do think it's important, as a lot of people have said, to decompose a little bit and to double-click down on some things.

You didn't have the opportunity in the chapter -- and I wasn't here as this was being laid out, but I've been struck over my experience about how different things are, depending on which state you happen to be sitting in at any given time.

So, when I was in Pennsylvania, we thought that benchmarking at 85 percent of Medicare was a pretty decent place to set the rates for providers. I was a little stunned to learn that Virginia had it at 27 percent, but it's working for them. And I don't think you can point to Virginia and say that the access problem, while there may be issues, is catastrophically different from access in Pennsylvania.

I was really stunned to get to Massachusetts and to be looking at Rhode Island and find that they're actually doing inflators above Medicare, and so I think that raises several issues in terms of are poor states subsidizing rich states, how is the money moving around. I

think you need to look at geographic variation. I think if we have variation at the provider price points, Medicare people -- there's lots of criticisms you can make of Medicare, but they've done it. They've made a reasonable effort to try and have equity across the country.

Medicaid, I don't think has done that, and it's potentially actionable. It will create winners and losers, but it is potentially actionable.

And so the other piece I want to point to with respect to pricing is, in fact, it's important to keep in mind, do states have the flexibility to set provider prices? Yes. But the way the market has consolidated over the course of the last several years, in many states -- certainly, this is true in Massachusetts, where I am now -- the health care delivery system is an important political player. They're major employers, and as they've consolidated, in some cases, some states have allowed the systems -- I think you could argue Virginia has done this -- have allowed the systems to consolidate to a point where each region has a monopoly, and that monopoly is too big to fail.

And so if you're a state decisionmaker, just how

much budget discipline can you apply there? And, again, getting back to this -- and what I would say from the managed care perspective is the managed care companies come in, we know we're going to have to pay a little more than the fee-for-service program, but, in fact, in every state I've been in in the last two decades, what you get is these consolidated systems drive huge rate increases in the managed care program, which then through the exercise of actuarial soundness goes back and drive the price point of the entire Medicaid program for that state. And this is something that if you look at the CHIA and Health Policy Commission data from Massachusetts over the course of the last several years, Massachusetts set a benchmark. We didn't want to be above 3.6 percent in terms of inflation. Commercial payers hit it; Medicare hit it; Medicaid blew through it. Now, part of that was enrollment, no question. But another piece of it was provider pricing, which has been difficult to put a ceiling on. And I do think that it would be worth, whether it's in a box or a couple sentences and whether it's in Chapter 3 or here, or a little in both, talking about the dynamics in the marketplace and just how much flexibility states actually have in terms of setting

provider rates, particularly in regions where there may be limited options in terms of who the providers are, and where may states still revert to cost-plus accounting in terms of their rate setting.

And so I think I'll stop there.

CHAIR ROSENBAUM: Thank you. Marsha, last comment, and then I'm going to try and wrap us up.

VICE CHAIR GOLD: Yeah, just sort of to come back, this chapter won't be able to solve every question that everyone has, and I think there's been a lot of good suggestions about a few areas that were mentioned. I do think it's important, if this chapter is going to be valuable to people, it has to tell them what to take away from it. And so however you do that, I think you have to come down to six main points. And that doesn't have to oversimplify. The text can say that this has all this in it that may do that, and one of your points could be a big area that the state -- you know, a lot of this, the dimensions vary a lot by state because this is a federal program, or maybe that's the beginning when you set it up, but this is what it looks like nationally. But if you can't do that, it's sort of useful data for people, but I

think that somehow don't -- I would be careful not to deal with all the detail that people have asked you at the expense of being able to communicate sort of some bottom-line things where they seem warranted to people, with appropriate caveats.

COMMISSIONER BURWELL: I'll make a quick comment. Given that over half of the total growth in Medicaid spending is related to the growth of the disabled population, both in enrollment and spending, I think a little more decomposition on why that's happening. Going back to what Alan says, it's not just a Medicaid issue. It's an issue related to our cash assistance programs. So just a little more, because it's such a huge part of the spending, what's driving spending.

CHAIR ROSENBAUM: Great. Thank you.

Just sort of to pull us together a little bit, what I'm hearing the Commissioners express is that, of course, the data are extremely useful, that we'd like to see a little bit more of the devices used in speeches. This is what we're going to tell you about, you know, we tell you the information, and this is what we've told you, this is what, as Marsha says, you should be taking away

from the information we've given you, that there are numerous drivers of spending. They have heavily to do with certain attributes of the program that have their roots in welfare. They have their roots in demographics. They have their roots in decisions made by the rest of the health care system about what is and is not insurable. They have some roots in what individual states bring to the program, how the health care industry itself behaves, and sort of this bottom lining that a lot of what you see in Medicaid is enrollment and spending per enrollee, which itself comes back to enrollment, and that, of course, is a factor of, you know, so many choices we've made about the program, so that we are using this chapter as the jumping-off point for the deeper discussions to come.

So thank you so much for a great job.

MR. PARK: Thank you.

EXECUTIVE DIRECTOR SCHWARTZ: I just want to mention something I should have mentioned earlier about these three chapters going together.

When the content has settled down, so subsequent to the kinds of conversation you have today about the messages of each chapter, since each chapter has to be able

to kind of stand alone, we will try to craft a box that can go in each chapter directing the reader to how it relates to the other two chapters. But I think that work is best left to the end when the messages have sort of settled down.

CHAIR ROSENBAUM: All right. So we are ready for what are really two chapters together.

REVIEW OF DRAFT CHAPTERS FOR JUNE REPORT: ALTERNATIVE APPROACHES TO FEDERAL MEDICAID FINANCING, AND ADDRESSING GROWTH IN MEDICAID SPENDING: STATE OPTIONS

* MS. HEBERLEIN: Okay. Thank you. And as Sara just said, Moira and I will present the next few chapters in the three-piece set. These two chapters draw on the Commission's meetings in October and January on state policy levers for addressing spending and the current Medicaid financing structure and various alternatives.

So as Chris just discussed, Medicaid represents a growing portion of federal and state budgets, and some policymakers view this growth rate as unsustainable and have suggested different mechanisms to cap federal spending as a solution.

In the first chapter we'll discuss here, the Commission presents its initial analysis of these alternative financing structures. But it's important to note that while changes could be made to constrain spending within the existing financing structure, that's not the focus of this chapter but could be the subject of future Commission work.

The second chapter we'll present here examines the tools currently available to states to address spending growth which will inform the question: Under an alternate financing structure, how might states take advantage to manage their program within those limits? We'll talk about state flexibility under current authorities, actions that states take now to curb spending, and some of the things that states have asked for in terms of more flexibility.

So I'll begin with the chapter looking at alternative approaches to federal finance and then pass it along to Moira, and then we'll listen to your comments and questions at the end.

So in the second chapter, we begin by describing the current financing structure, commenting on its origins as well as outlining features that have led to criticism.

We'll then provide an overview of several major approaches to financing reforms, noting how these work to reduce federal spending, and highlighting key decision points.

Finally, we'll end with a brief discussion on the potential effect on states, enrollees, and other programs.

So, beginning with the current financing structure, financing the Medicaid program is a shared responsibility of the federal and state governments. As long as the state operates the program within federal requirements, it can receive federal matching funds towards allowable state expenditures, including payments to providers and other administrative expenses. Because federal contributions match state spending on an open-ended basis, as state spending increases, so does federal spending.

These increases can be the results of state-specific decision -- for example, increasing eligibility -- or the result of factors that are typically outside the control of states or federal government, such as changes in the economy, the emergence of new diseases, and medical innovation.

The ability to respond to these outside events is

one of the advantages of the current financing structure and helps Medicaid meet its unique and varied demands as a source of health coverage for low-income individuals.

The vast majority of states' Medicaid spending is for health services provided to Medicaid enrollees, and the federal share for most of these costs is determined using the Federal Medical Assistance Percentage, or FMAP. And as you know, the FMAP formula provides higher matching rates to states with lower per capita income and is intended to account for states' differing abilities to fund their Medicaid programs.

So looking at the state side, state responsibilities and their incentives, the Medicaid statute permits states to generate their share of Medicaid expenditures through multiple sources, including general revenue, contributions from local governments, and specialized revenue sources such as health care-related taxes. As a result, the extent to which states rely on any particular funding source varies considerably.

The ability to draw down open-ended funding is a major component in state spending decisions, but other factors also shape state choices. For example, while

states may wish to draw down federal funds for programs that are solely state funded, they will still need to raise state matching dollars and do so in the context of a balanced budget and with other competing priorities, such as education.

However, even within these state constraints, federal spending depends almost entirely on the amount that states spend. This open-ended funding structure raises concerns for federal policymakers, especially those who are interested in limiting the federal financial exposure. Proponents of capping the federal share of Medicaid suggest that such a change could lead to federal savings and could potentially eliminate some of the incentives states have to maximize their federal dollars.

So Moira talked about these four major alternatives at the last meeting. The chapter draws upon what she has already presented as well as providing some additional context and examples and hopefully draws in some of your discussion from the last meeting. But as a refresher, I'll walk through each of these four alternatives quickly.

So block grants are structured to provide lump-

sum grants to states with amounts based on a predetermined formula. The states typically do not provide matched funding, but may be required to -- may be subject to a maintenance of effort requirement on existing spending. So TANF is an example of a block grant.

Under a capped allotment program, they act as a ceiling with federal funds being matched up to a cap. States are required to contribute a state share and may receive less than the full amount of their allotment, depending upon their own level of spending. So CHIP functions as a capped allotment.

Under a per capita cap, policymakers would establish a per enrollee limit on federal payments to a state with spending rising based on the number of enrollees. Budget neutrality caps in Section 1115 waivers are typically structured in this way.

Under a shared savings approach, the federal government would continue to provide matched funding for eligible state expenditures based on the FMAP while providing a share of savings for spending if spending falls below established targets.

It's important to note that these approaches can

be designed so that the level of funding is more or less or higher or lower, restructuring would have different results depending upon what program features are included and how it is designed.

For example, while functioning as a capped allotment, the CHIP financing structure was not designed specifically to limit federal financial exposure. In fact, for the first several years of CHIP, states' allotments tended to be much larger than their actual spending. But later on, as the program matured, the allotments were increased when states raised concerns about their sufficiency.

So thinking about the design considerations when establishing spending limits under a proposal to cap federal Medicaid spending, policymakers would need to consider how to establish the overall spending level, how to trend that level forward, and in some cases how to set state or eligibility group specific caps. These decisions will likely reflect the goals of the reform, although data limitations, as we're all aware of, may also have an influence. So the chapter goes into a little bit of detail on some of the data needs as well as some concerns or

constraints around the data, including the timeliness. But here I'll focus on some of the other just overarching design considerations.

So in order to set a national spending threshold, policymakers would likely begin by choosing a base year. And while prior-year spending may not be an accurate reflection of current-year spending, choosing a year without available data would require trending current spending forward and basing on some assumption of growth.

On growth factors: policymakers may also want to consider how to increase spending going forward. For example, if the goal is to reduce federal spending, they may wish to keep funding constant or limit the growth factor to something lower than expected under the current law. On the other hand, if policymakers choose to include the rising costs of medical care, as in the CPI-U that Chris just showed, it may not stem the increase in federal spending.

Determining how to allocate spending across the states is another decision point. Basing future state spending on current spending would lock in existing differences that reflect both the policy preferences and

the availability of state resources. Conversely, if a cap was designed based on the national average, states with lower spending levels would receive new resources while those with higher spending levels would be forced to make reductions.

Finally, in establishing per capita caps, which would be relevant in a per capita cap situation or a shared savings approach, you may want to consider setting caps for each eligibility group, which may be a more accurate reflection of costs as per enrollee spending varies across eligibility groups, as Chris just showed.

An average cap would obscure this difference, but establishing and risk-adjusting caps for each state and for each of the four major eligibility groups would be complex, especially given the limitations and inconsistencies in Medicaid administrative data.

So a few additional design considerations. Given the size of the states' contributions to Medicaid, it is difficult to imagine a change in the federal financing without assuming some sort of state contribution going forward. For example, under a block grant, this would likely be in the form of maintenance of effort, while under

a capped allotment, policymakers would need to specify the federal matching rate.

Policymakers must also weigh which aspects of the program will fall under the new approach and whether to exclude certain groups or certain types of spending. For example, one of the distinguishing features of the Medicaid program is its major role in financing long-term services and supports. There have been some proposals that have excluded this population from a restructuring; however, since they are a large source of spending, such a proposal might not save a lot of money.

Proposals to restructure Medicaid have rarely touched upon the level of ongoing accountability for states in much detail. They typically stipulate that for less federal dollars, states will have increased flexibility. However, with this increased flexibility, there may be less ability for federal decisionmakers to evaluate whether federal dollars are being used in the best way. So under a new alternative, policymakers will need to decide what the appropriate level of federal oversight is for those federal dollars.

So the chapter concludes with a brief discussion

of the potential impact of these changes. So if the goal of reform is to increase federal budgetary savings and predictability, as has been the impetus for much of these discussions, policymakers are likely to decrease the level of funding going to states either initially or over time. Under such a scenario, it may be difficult for states to find efficiencies within their programs to offset this decline, and instead they may look to other options to control spending in Medicaid. And Moira will discuss in more detail the tools states have to make these changes within the existing rules.

The effect on beneficiaries of any financing change depends on the level of funding provided to states, how states react to that level of funding, and the amount of flexibility they have to make changes. Theoretically, enrollees could see little change if states maintain their existing programs by raising revenue in response to these decreased federal funds. However, experience has shown that states have struggled to close budget gaps in their Medicaid programs by raising revenues and instead have turned to reductions in the program.

Finally, changes to Medicaid will also likely

have spillover effects because of its interaction with other programs that serve low-income populations. For example, Medicaid currently provides financial assistance for Medicare premiums or cost sharing for low-income individuals who are dually eligible, and as policymakers move forward with any financial restructuring, they would need to think about the spillover effects on these populations.

So now I'll turn it over to Moira, who will talk about the third chapter in the series.

* MS. FORBES: Sure. Thanks, Martha.

So this chapter, as we've said, talks about how states currently address growth and Medicaid spending and what options are available at the state level.

So to complement the discussion of the options for assistance that limit total federal funding, again, I think we are working off an assumption that if federal funding was less open ended, then states would have an incentive to be more efficient, particularly if those models are coupled with additional flexibility to allow states to make changes that better address their local preferences.

So we have compiled some information on both the options that states have now and how they're using their flexibility under current authorities to manage their programs and manage spending. Those of you who were on the Commission last year will remember that Jim Teisl and I presented some of this material last October, and we took some of the suggestions from your discussion at that time and tried to incorporate them into the chapter.

We have added some examples of where states have sought flexibility beyond what's currently allowed under statute, as these are areas that might be subject to discussion as part of a broader discussion of changes to overall federal financing reform.

The chapter covers five areas in which states make policy decisions and exercise flexibility to manage their spending, as noted on the slide. In each section of the chapter, we discuss the current statutory and regulatory authorities and how states are using these options now. We give some examples, and I'll walk through some of the examples on the next few slides.

So, as Chris said in the first presentation this morning, program enrollment is the largest factor

contributing to increases in Medicaid expenditures over the last 30 years. However, annual surveys of state budget actions show that states -- and I think Martha just said this as well -- are less likely to try and make major changes to eligibility to reduce spending. These are often the last cuts they'll propose because the effects on enrollees. They'll exhaust other options first. In addition, Congress has at times imposed maintenance-of-effort provisions, which have prevented states from reducing eligibility standards.

So we talked about what the current eligibility requirements are for states, what's mandatory, some of the options. We have found in looking across states that where states have flexibility, the take-up of the optional groups really varies. For example, almost every state -- or maybe every state -- covers the optional group of women requiring treatment for breast or cervical cancer, which is an option they've had since 2000, but only 13 states have extended Medicaid coverage to a much newer optional group, which is youth who have aged out of foster care in other states. And, of course, many states have chosen not to take up the optional adult expansion group.

Recently, a few states have requested 1115 demonstration authority to test alternative eligibility requirements in conjunction with that optional adult expansion, including charging premiums, requiring enrollees to make monthly or quarterly contributions to the cost of their care, and being able to disenroll and lock out higher income enrollees for failure to pay premiums. However, CMS has been unwilling to approve some state waiver requests, such as making a work requirement or a work referral a condition of eligibility.

Increases in the cost of providing Medicaid benefits also contribute to the overall growth of Medicaid spending. This section of the chapter describes some of the high-level options available to the states around coverage and management of Medicaid benefits.

State decisions to cover optional benefits, of course, have a significant effect on overall Medicaid spending. Similar to eligibility, when we look at the optional benefits, there's a lot of variation across states. Every state covers prescription drugs, but only about half of states currently offer adult dental, which is an optional benefit. And we talked about that in our June

report last year.

Even among the benefits that states choose to cover, the breadth of coverage varies a lot by state. Dental is a good example. We found that states -- of the states that provide optional adult dental coverage, they placed very different limits ranging from annual limits in the number of fillings or crowns, the types of crowns that can be used on certain teeth, how often root canals and be performed, annual dollar limits, limits in the amount of service you can get in a certain amount of time. I mean, there's a lot of ways in which states manage the benefit, and it results in a lot of variation across states.

We're seeing more requests from states to waive certain mandatory benefits, particularly in conjunction with the adult expansion. Two states -- Iowa and Indiana -- have received time limited waivers of the requirement to provide nonemergency transportation services, but CMS has also denied some requests to benefit changes, particularly the requirement to provide EPSDT services to newly eligible adults who are also 19 and 20 and therefore otherwise eligible for EPSDT.

States can add or drop entire categories of

optional benefits for Medicaid in response to changing economic conditions, or they can make incremental changes, and we see them doing both. Dental is again an example. Between 2003 and 2012, 20 states made changes to their adult dental coverage, and 3 states have dropped it entirely. So, I mean, we certainly do see states exercising their flexibility in this area.

States also have the option to impose cost sharing on certain benefits for some groups of enrollees. They can establish different copayments for generic and name-brand prescriptions, for example. Again, in some cases, states have been granted authority under demonstration waivers to test different approaches to the use of cost sharing for Medicaid beneficiaries, but CMS has also denied some waiver requests, for example, to allow aggregate cost sharing to exceed the 5 percent income cap.

The draft chapter briefly discusses the considerable flexibility states have in determining provider payment methods and amounts, which we covered in a lot more detail in a report chapter last March.

The annual state budget surveys that Kaiser has done for the last 15 years or so shows that when facing

fiscal pressure, states often prefer to reduce or freeze provider rates before making other program changes that more directly affect beneficiaries, such as benefit or eligibility changes.

During the economic downturn from 2001 to 2004, every state froze or cut some provider payments to control costs, and during the next recession from 2008 to 2010, although states got additional federal support from the stimulus bill in the form of enhanced FMAP, again, every state made some provider rate changes.

We have looked at the last few years, as economic conditions have been improving, and states are definitely less willing to implement provider rate cuts. States have increased provider rates in a lot of areas that bring them back up to former levels. The most recent survey found that this year, only a handful of states have implemented or planned any rate changes, like three to five states in the areas of hospitals and nursing facilities and so on.

Of course, there's limits to how much, I think, as was discussed earlier, there's limits to how much states can constrain provider payments. As noted on the slide, the federal equal access rule requires Medicaid programs to

ensure that payments are sufficient to ensure equivalent access within a geographic area. The market dynamics, the payment policies of other payers, particularly Medicare, also affect a provider's willingness to participate in Medicaid at a given provider payment level.

As an alternative to cutting eligibility benefits or payments, many states have implemented delivery system reforms, which are generally intended to counteract the sort of inflation -- inherent inflationary pressure of an unmanaged fee-for-service system. So a lot of states have implemented managed care programs, which provides states with access to more tools to manage per-person spending and spending growth, and also gives states greater cost predictability while allowing them to enforce standards for access and quality.

While payments to managed care plans must be actuarially sound, many states have turned to managed care to reduce costs in the short term because capitation rate methodologies can assume that managed care plans can achieve some savings relative to fee-for-service.

Most recently, there's been a lot of talk about value-based purchasing initiatives. We've presented a few

times on site visits we've done to states that are doing ACOs or bundled payments and so on. While some of the models have generated positive results to date, we haven't seen evidence of significant or sustained savings. A lot of these things are fairly new.

We've also looked at efforts Medicaid programs are engaging in many states around multi-payer reforms to design new payments, service delivery models, although again, I think a lot of these models, the results so far are sort of inconclusive or mixed.

A lot of these efforts, I would say are focused on bending the cost curve and not really in terms of getting immediate cost savings, so we'll continue to look at those as another strategy states have to control costs.

Finally, the chapter talks about program integrity. We certainly often hear about reducing waste as a way to reduce spending. The chapter notes that states and the federal government conduct a variety of program integrity activities intended to ensure that federal and state taxpayer dollars are being used appropriately.

MACPAC and others, including the GAO, have certainly noticed the challenges in implementing effective

and efficient Medicaid program integrity practices, and specifically, I think many policymakers have noted that ongoing or additional investments at the state and federal levels are needed to enhance and improve both the front-end program integrity controls to prevent fraud as well as the post-payment reviews to identify waste, fraud, and abuse.

While these investments can reduce the amount of program dollars wasted on improper payments, they can't be eliminated entirely as the cost of identifying every potential improper payment at some point outweighs the cost of doing those reviews, and puts a lot of burden on legitimate providers.

So in terms of our next steps, we'll take the feedback we get now and factor them in as we finalize these chapters. Going forward, depending on the direction we get from the discussions today, we expect to conduct additional analysis of the design and technical considerations -- many of which Martha raised in her chapter -- associated with alternatives to the current financing structure. In particular, areas that we think warrant further exploration are where there are existing flexibilities and what are the areas where additional flexibility has been requested and

what are the considerations with regard to Medicaid's relationship to other federal programs, such as WIC and foster care and Medicare and so on.

CHAIR ROSENBAUM: Thank you. You know, it struck me as you were talking that we might, going back to Marsha's point about the sort of context setting, I think that one way we might connect these chapters into a whole is to maybe spend a little bit more time on the fact that flexibility, state flexibility has been part of the DNA of the Medicaid program since it was established. I mean, the program's hallmark has been flexibility, and a lot of the most important policy reforms have been designed to give states additional flexibility.

And that beyond targeted policy reforms that broaden states' horizons and how they responded to particular emerging needs and problems in their state, that it's the federal financing itself, which has been a driver of the flexibility; that is, you have a federal payment structure that operates by lots and lots of rules, and the rules are very important to the overall structure of the program and to the integrity of the program. And they've changed some over the years, but that in fact, it is the

historic approach of federal funding that has in fact made it possible for states to have a program that is responsive to the needs of their population. So if we're looking for ways to sort of bridge between one thread of the discussion and another, that might be a point to pull out.

So general discussions about Chapters 2 and 3?

COMMISSIONER COHEN: Great presentations and great chapters, so thank you.

I just wanted to raise an issue that sort of kept coming up for me in Chapter 2, and it is a general point but maybe not quite to the heart of the matter. I think that we often conflate a little bit sort of the issues around what the financing structure is and its relationship to sort of what the regulatory or sort of programmatic requirement pieces are. So we sort of assume, because many proposals have brought these two together, that a block grant is accompanied by some relaxation of programmatic requirements on what things can be spent on, but that's not inherent. It doesn't have to be that way, and the question of what is relaxed is, of course, a huge and tremendous question.

So I just think in all the ways that we talk

about this subject area, we just have to be really careful in talking about what is the financing mechanism and its impact, which frankly in many cases can be much more sort of long term, not like “what did we spend yesterday” and “what are we spending tomorrow”, but sort of like “how does this change over time” and kind of what incentives are and separate out for a different and incredibly important conversation, what the programmatic requirements for any of that spending are going to be. But I think we have kind of taken -- because proposal -- to be a policy proposal, you have to combine those two things, but how you combine them, there's nothing inherent in it. So I just think we need to be really careful because there were places, especially in the second chapter, I felt like they were kind of conflated.

And you can have a block grant and say every rule remains, and you could have a block grant and say, "Here's the money, and call us next year when you want a check." And those are incredibly -- the impacts on anybody would be incredibly different based on that. So I just wanted to flag that.

CHAIR ROSENBAUM: Chuck and then Toby.

COMMISSIONER MILLIGAN: Thanks, Andy. I'm going to come back to that comment as well in a second. So, again, like I did with Chris, some very specific comments, and then I have more thematic things.

Slide 9, when you are talking about design considerations -- sorry, didn't mean to do it quite like that -- one of the issues is going to be equity across the states, and having lived through the Medigrant debates in '95, a lot of what that turned into was whether it's block grant, whether it's per capita cap, whether it's X or Y, if one state is getting disproportionately better treated than another because of where their base starts, it leads to a lot of equity issues. So that will be a design consideration, just the state versus state part of how that might play out.

Slide 13, where you mentioned cost sharing, I think that however the chapter gets finalized, I think cost sharing is a tool that ought to be called out more specifically as not just eligibility benefits, provider payments, delivery systems, and program integrity, but cost sharing is pretty fundamental. As we've seen with a lot of the 1115 waivers that have come out of the ACA debate,

should there be expectations of paying a monthly premium, out of pocket for inappropriate use of the ED, those kinds of things? So I think it's worth calling out separately.

Slide 15 -- and I might stay on this for a minute -- benefits. And I'm going to come back to the amount, duration, and scope part of this, but there's other benefit tools states have, one having to do with kind of utilization management-type tools, a medical necessity, if you will, but it can even include -- and to Brian's wheelhouse -- where one state sets its nursing facility level of care compared to where another state sets its nursing facility level of care and the ability of the state to say, "We're going to change that. We're going to be more restrictive in terms of how many ADL deficits you have," that drives both availability of the benefit and also drives eligibility. But sort of the UM piece of that and medical necessity, I think another example is the way states have built, functionally built preferred drug lists. So I think that just the benefit, the UM piece of that is worth calling out.

So now I'm just going to go to more of the thematic pieces. I think it's worth mentioning that the

states also have opportunities on the revenue side, not just the cost containment side, and where most people go with that is then provider taxes and all of that stuff. But I'm also talking about rebate arrangements, exclusive contracting arrangements. Some of the nonemergency medical transportation you see is trying to get volume purchasing agreements. So there's a revenue piece. There's a rebate piece. I won't get into all of the examples of revenue, but I think the revenue part are tools states deal with when they're in budget situations all the time.

And then two higher level comments. The first is what I think gets lost in a lot of the discussion is that the fact that the trend is, more or less, reasonable, as Chris showed in the first part, reflects a lot of the work that has in fact been done and continues to be done, not just kind of managed care, but all of the program integrity and all of the program design and patient-centered medical homes and rebalancing. All of that from the state perspective -- and I was in a meeting several years ago with some CBO folks -- from the state perspective, the fact that trend comes down but there's no credit given, because those are available tools in the law, and you can only

score savings where there's a change in law -- I remember Barb Edwards, then-Ohio Medicaid director, saying, "We don't get credit for this in your guys' eyes? Everything we've been -- the blood, sweat, and tears we've been living through?" So I think that it's worth noting that the work that has been done has in fact affected the trend in a positive way.

Last comment, and I think this is to me the crux of it. And I'm going to come back to Andy's comment. From the state perspective, it's the current situation -- and it will be part of the debate if there are changes to the financing -- is at a federalism level, how much more discretion and authority would states receive or not? And I want to -- there's a couple points I want to make about this.

The first is, from the state perspective -- and a lot of states, independent of partisan reasons and all that stuff -- part of their frustration with the status quo is that the Medicaid Act and the regs and other things permit certain things states could do, but CMS won't allow them to because CMS might, regardless of the party and the era, superimpose its policy judgment where the framework allows

state actions. And that tension, which is inherent in Medicaid, I think is underneath a lot of -- from the state perspective, the view that if a state wants to change its benefits or amount duration and scope or add cost sharing or add a work requirement or whatever the case may be, that CMS superimposes its policy judgment. And that tension, which would be inherent in the debate about changing the framework, block grants, per capita caps, how much discretion do states get or not, I think is underneath the status quo. I don't think it's articulated, and it can be done neutrally to say the states submits state plan amendments. They submit 1115s. They don't necessarily get them granted, even if what they're asking is allowed.

And I will give one very specific example, and then I'll stop.

With the amount, duration, and scope, when I was managing the Maryland Medicaid program through the recession/budget crisis, we were thinking, okay, should we limit the number of covered inpatient hospital days to 20 days per person per year as the coverage of the benefit, and thereafter -- you know, with kids, EPSDT creates a lot of protections, but with adults you can kind of look at

those things. And we learned in our conversations with the CMS central office that there's this kind of unspoken, unpublished ground rule that it could be considered if 90 percent of your Medicaid enrollment would fully be covered by that 20 days, let's say, and that we had to do a data analysis and say, okay, if we've got at the time 800,000 people on Medicaid, would 720,000 of them have fewer than 20 inpatient days a year? And, otherwise, it wasn't going to get approved.

And as it turns out, we didn't submit the request -- not for that reason, but that unpublished, non-regulatory, non-Social Security Act framework underlies, I think, a lot of the state view that when we talk at a theoretical level about flexibility, when the rubber hits the road, there's a lot of federalism tension underneath that is not resolved. It becomes part of the design debate of any kind of proposed future state. And I'll stop there.

CHAIR ROSENBAUM: Thank you.

COMMISSIONER DOUGLAS: All right. In California, we did submit one of those state plan amendments -- I'm looking at Penny -- and it never went anywhere.

Really good chapters, and I'm going to kind of

touch on similar comments.

First, some more in the weeds, around the discussion on optional benefits, you know, from my perspective -- I mean, the optional benefits are really on the margin. When you start looking at it, I mean, this just needs to be called out somewhere. We're not talking big dollars on a lot of these optional benefits. And when we looked at it, I mean, yes, it makes a difference. But in the macro level, when we're talking about spending trends, the optional benefits are not where the big dollars are. Dental is not a big driver.

And then the other piece that needs to be kind of incorporated -- and I think it's been a theme from the last meeting, and this is managed care -- is that when you start getting into managed care, it's really hard to start even eliminating these optional benefits because of the intersection with other services and the actuarial soundness and how they'll push up other trends when you start taking away certain important therapies and others that will then impact other utilization and just shift it to somewhere else.

The same on provider payments. We talk a lot

about, you know, the fee-for-service access, but, again, we're in a lot more managed care, so it's not as simple to cut payments in a world of managed care. So there's that tension between the delivery system and those kind of optional benefit and -- I would say the other is on cost sharing, and this is where, you know, to CMS' defense, you know, I wouldn't -- the cost-sharing statutes, we tried to change them. There are a lot of statutory protections that prevent any real meaningful cost sharing. It all has to be at the end of the day for most of your population voluntary, that they don't have to do the cost sharing. So unless it's higher-income groups, which most of them, they can show up, present in an emergency room, and they don't have to pay it, and that's statutorily defined. So I think this cost sharing only goes so far, but don't go far -- you know, some would say maybe don't go far enough. And I'm going to come back to that.

A couple big themes. One from a state perspective lays out the provider taxes, you know, county spending. I do get concerned -- I don't know where to fit this in -- of just you take away that money, if there's any talk about it, it still doesn't deal with the underlying

spending trends. Where's the money going to come from? You can take that away, but the rules and everything are there still. So looking at that isn't necessarily the big solution to the overall spending trends. And it might be also just analytically looking at us going forward. Is this component going to grow at the same rate? Or, you know, even if you took it away, both from -- in fact the state general fund would probably have to fill in the gap. It's not just going to mean a reduction if everyone else stays status quo. So that's one piece of it.

The other is on just the discussion in the paper on -- I felt there was a lot more about -- talking about states spending more and not -- you know, from a state perspective, even if there is financial incentives, in general they're not willing to spend more state dollars. And it's mentioned, but just felt it wasn't -- you know, states do not want to spend a lot of money. And, you know, even -- you know, so there are -- there are -- some states do, but in general, states won't want to spend more.

And so then the final piece gets back to kind of flexibility or even on what Kit was saying, is I just question that there's a whole other way to look at this

besides the floor. It's just more what if there were more flexibilities, what do those factors -- how do they change the rate of growth, whether it's, again, back to cost sharing and having change, if there was, as Kit said, some more -- and it's not flexibility, but more federal direction and control over rate for, you know, especially in a managed care setting where you have -- it gets at a lot of contracting issues that go on with delivery systems and, you know, the prices going up more than expected within managed care. There was more control over that similar to -- there was the Rogers Amendment that dealt with non-emergency inpatient rates.

What would those types of -- how would that impact the rate of growth rather than just saying block grants or any of these? Are there other ways to look at this that might be better, especially -- and then the other is Medi -- the intersection between -- and I know this maybe is getting out of our purview, but the Med -- most of the costs are on the disabled adult, long-term care, duals. What is there that could be done within, you know, the Medicare around requiring -- you know, one that comes to mind for states is mandatory enrollment in special needs

plans for the Medicare population, coupled with long-term care to better organize and deliver and reduce the overall cost of care and align incentives there. So things like that, is that another approach we could take?

So I'll stop there.

CHAIR ROSENBAUM: Thank you.

VICE CHAIR GOLD: Yeah, I was trying to think through, again, the logic, and there's a part of me that wonders whether we do better with moving Chapter 3 in front of Chapter 2, because Chapter 3, even though it says it's looking at what you could do if you did all these other things, is really saying how can states control costs or not now and where are the constraints. And it helps make some of the points that I think people had in discussion of Chapter 1, some of the more nuanced points would fit in 2. And essentially I think what that chapter is -- what 3 is saying is that there's program scope, which you have enrollment and benefits, some of which are optional and some of which -- most of which are mandatory.

Then you have a tradition of an originally fee-for-service program that you could play with rates, and people have certainly done that. That's been the preferred

when -- there's a sense that there's not much more there, or maybe there is, whatever the truth is, you know, of what we know there.

Then where I think we need to sort of make it more apparent that states really have been putting a lot of their effort now in the delivery system reform area because they feel like rates don't quite get it, and you have to get better value for what you're getting and give more incentives as to what the mix is of what people do and how care is delivered. So that started out with the capitation payments in managed care, and those have continued, and I think rather than cite -- there's a good review by Robert Wood Johnson Foundation that Michael Sparer did of what we know about Medicaid managed care up until maybe 2010 that we could cite that and we can do a little better job with the literature.

But then there's also been more recent effort even to affect value within the fee-for-service program or to do other things, and that's picked up, but some of the links to some of the CMMI activity and the innovation grants and even working with other payers. I think there's a real question -- oh, and then you get to fraud and abuse,

and, of course, how much you can get out of that, and I don't know what we can say.

But that kind of sets it up, I think, for the next chapter in that the question is: What do you get with these other ways of doing it versus how things work now, what does that get or not get you or what Congress might get? Because one of the questions is your main motivation is to save money as opposed to change the pro -- you know, if you're looking at it from a cost containment point of view, what do things get? And I might actually reverse the order of the different -- of the ways you have here, because they're essentially -- I mean, the first two are working more at giving states more incentive to control costs and the costs per person through delivery reform or through other ways of doing it. And then as you move up, you get more global with what you're doing.

And I'm wondering if at the end we're -- you know, and we might say something about the history of block grants and what requirements come with them. I don't know. To my mind, it comes down to how much money do you think you should spend? If you want to spend a lot less, I don't know what we think the research says about whether we could

-- you can get away with doing it without controlling benefits and enrollment in some way, whether that's in the existing structure where you change some of the requirements, or whether that's through some of these other ways, because that's where the money is.

Now, you can have the other alternative. There's the fraud and abuse alternative. We can get rid of that, and that'll save enough. I'm not sure how much that saves. Or you can reorganize the delivery system, and there's hope, even though the evidence doesn't show it now, that you get some savings there. And we don't know the answers to these questions, and a lot of them are value judgments on how much money we can spend, which I think the Congress is the one that gets paid to decide.

But to me, those -- yes, you can spend more or less in each of these areas, but if your main motivation for starting out isn't to look at an ideal structure but to figure out what you want to have happen, I'm wondering if we should be more explicit about what some of the tradeoffs are and the logic behind moving this this way.

CHAIR ROSENBAUM: All right. We have time for Penny, Alan, Kit, and Brian, and Sheldon before we break.

COMMISSIONER THOMPSON: I'll try to be concise. I think I'm building a little bit on what -- and I'm resisting the impulse to get drawn into an amount, duration, and scope discussion with Chuck. But the -- I don't know on Chapter 2 that I'm entirely satisfied with our characterization of the current FMAP formula and what it does. I think you've made a terrific effort at that. But, you know, it's often said the most popular person in town is the backup quarterback, and I feel like that's some of what's going on sometimes with these debates, which is that we're living with the current formula, and so we have a really keen appreciation of both its pluses and its minuses, and its appealing parts and its unappealing parts, and its efficiencies and its inefficiencies.

And then when we compare it to other situations that have actually not been implemented, they can appear more attractive, but it's only because we haven't really examined or experienced them in the same way.

So sort of building on Toby's point, I think, particularly about whether or not it really is the federal match that drives a state's decisions and when and how it drives a state's decisions I think we may be -- although,

again, you've struggled with trying to present this, but I think that it may be a little overstated in the sense that there's a floor and there's a ceiling and that has to do with what you have to do to get the match and what you can't do to get the match.

And no matter what the limit of the match that you can get -- like in some ways we are having a conversation in which we're saying seemingly contradictory things. We present the strain on state budgets as a result of the need to fund the state's share for the Medicaid program. I've never thought that putting the federal dollars in a state budget made any kind of sense in terms of understanding what's really happening.

So if you look at it from the state has to fund it and we talk about the pressure and the stress and the crowded-out other priorities caused by Medicaid, states have a great deal of incentive to save every bit of a state dollar that they can in that particular environment. They are constrained in whether or not they can trade a state dollar for a federal dollar in various ways in the formula. And no matter what, they're constrained by their ability to draw down a federal match, even if they were motivated to

do so by a variety of different kinds of factors. So I'm not sure that we've presented a full appreciation of all of those kinds of considerations that come into play.

And so, consequently, also, I wonder if we're missing an option, which has to do with I guess I'll call it -- I might just be by nature an incrementalist, but it's sort of like an improvement with the current financing -- and maybe this is picking up on some things that Chuck also said, which is that you could maintain the current financing, you could address certain particular issues or concerns that have arisen within that financing formula that could include providing some states some additional levers and tools and authorities. It could be providing more of a -- supporting more of a performance culture with some benchmarks, which maybe brings in some of the shared savings approaches and so forth. But you could still maintain fundamentally an FMAP structure and hybridize it in some ways with some of these other concepts or other activities that would promote more efficiency. And I think in the end that just gets back to, I think, Marsha, where you're going, which is: Is our purpose here to reduce spending overall? Is our purpose here to reduce federal

spending? Is our purpose to provide predictability in what the federal government has to budget for in terms of supporting the Medicaid program? Or is it promoting productivity and efficiency of the Medicaid program alongside other health care programs? And I think depending which of those we're trying to accomplish, you know, I think that our view of the available options might be different.

EXECUTIVE DIRECTOR SCHWARTZ: And, Penny, would it work if we raise some of those concerns and talk like the way you have just talked now about some of these things as areas that we would develop in future work, rather than trying to do a full dive into those now, that we could still preserve the essential structure with some caveats and then at the end about some conclusions that you have raised and that the others have raised, too, and then have that be an area where we could spend a lot more time in the future.

COMMISSIONER THOMPSON: Yes, absolutely. And just to finalize this point, too, I think some of the other points in Chapter 3 and whether we reverse them or not -- and I could see that argument for reversing. It's almost,

again, kind of reverse engineering, which is if there are known ways that the Medicaid program can become more efficient or productive, what are they? And what's stopping them from happening? And is what's stopping them from happening some kind of state budget or federal financing issue? Is it programmatic or statutory authority? Is it the inability to have the political muscle to implement it or something else? And I think that kind of reverse engineering of kind of saying where does that efficiency or productivity reside and why isn't it happening, and is it common to Medicaid or uncommon? Is it just Medicaid or is it the entire health care system that's also struggling with those kinds of issues? And then I think we could determine whether or not some changes in federal financing are actually needed in order to enable some of those activities.

COMMISSIONER WEIL: Okay. Many of these issues have been raised. I'm going to try to just do an incremental tweet in the interest of time. Four points.

The first is, like Penny, although I know Chapter 2 is forward-looking, I think the description of what we have now is critical because it does raise the question of

whether there are incremental approaches in addition to these broader ones. You begin with the comment that most payments are associated with services. The way I've always thought about it is that payments are for a covered person receiving a covered service from an eligible provider at an allowable price, and those are all levers you can move. There are supplemental programs that are not tied to individual people. There are administrative, you know, MMIS and fraud, that are outside of that. And then there's an overlay of permissible revenue that the state can use for match. And it seems to me laying out the structure is important even though I realize most of Chapter 2 is about changing the structure.

The second -- and I think this echoes something others have said -- I found the sentence that state spending is constrained by balanced budgets and 40 percent requirement, that just feels to me like a non sequitur. State spending is constrained for lots of reasons, and I wouldn't highlight those two.

The third comment is aligned very much with Toby. I think -- and it goes back a little bit to Chapter 1, which is that we've got these long lists, but we're not

focusing the reader on the important elements. So this sense of how big is the bread box, so, you know, emergency transportation is important, dental is important. It's not as big as prescription drugs or HCBS or something like that. And whenever we're looking at these flexibilities, to give some sense of the scale, so it's not just a list of all the things that states can do.

And the final comment I would make is that I think the review of the flexibility states have is very helpful. What it feels like it's missing is the context of this flexibility states have been asking for years and years and years and years. And, you know, I think it would be an interesting exercise -- I've never done it -- to take all of the NGA policy statements on Medicaid for the last three decades and, you know, the themes emerge: higher cost sharing, tailored benefits to different populations, mandatory Medicaid managed care, behavioral requirements on enrollees like work requirements, and then the one that Chuck brings up that I think has to be in here, which is the whole process issue, the federalism issue. Do a Google search on "Medicaid waiver" and "come to Washington on bended knee," and you will hear that that's how governors

think of waivers. NGA policy, if one state gets a waiver, other states should be able to just Xerox it and submit it and get the waiver. I think there's a whole sense of sort of what's the approval process, what's the discretion, that is absent from this discussion.

So I think trying to not just talk about what flexibility states have, but to put it in the context of the fairly consistent list of types of flexibility that states have been requesting for a long time.

CHAIR ROSENBAUM: Great. Kit?

COMMISSIONER GORTON: So just a quick tag on what Alan was saying, the Governor of Massachusetts, who some of you may know, used to be a health plan executive. Now as part of his pat speech to groups he says that the governors are just butlers in the health care policy arena, and that with the ACA, the health policy has been completely federalized, and there's very little that governors can do to change how anything happens. I'm not endorsing that. I'm merely saying that that's where the conversation has gotten to.

So, quickly, in terms of, one, I was really struck that premium support didn't appear anywhere in these

two chapters. We have interest in premium support from lots of states, and it's an option that's available now. It's never really gotten anywhere. I am sure I don't understand why it's never gotten anywhere, but it doesn't take off. If you walk around, most states have a tiny program along the side, but I think it would be worth mentioning that it's something that's there, and particularly given the Arkansas model and some of the other pieces, it seems to be silent on that is just an oversight.

I think it's worth talking under the sort of general rubric of administrative things. We talked about administrative things states could do. There's very little uptake, despite a lot of conversation about bundled purchasing and bulk purchasing and how states could use their buying power.

Back in the '90s, there was a lot -- and Minnesota sort of led this -- in terms of how do you use the state's health care purchasing power to get good pricing, you know, thinking about state employees and everything else. The Colorado waiver really looks at -- is it Colorado? One of the waivers out West now looks heavily at how you use the state's purchasing authority. We hear

very little about states banding together to buy stuff that's commodity stuff, which if they banded together, they could probably get at reasonable cost. And some of it is stuff like Sovaldi, right? If you couldn't sell Sovaldi in 15 states unless the price was lower than $1,000 a pill, my guess is the price would come down below $1,000 a pill, just a supposition there.

The second thing about administration is many states budget administrative expenses separately from programmatic expenses, and some states -- Alabama comes to mind -- have formal caps on how much you can spend on administrative costs. That means the state's capacity to purchase services, to do analytics, to have people who can do all the modeling and stuff that needs to be done to hire consultants is severely constrained. So I do think that one element of why states don't do some of the stuff they could do is they simply can't afford to do the analysis and lay out the implementation, and so is there a way to deal with what I think is a technical assistance gap? And I think CMS has tried to address that in a small way over the years, but when you come down to doing the actuarial modeling for some of these programs, that is expensive

work, and in some states, they simply don't have the money to pay for it.

And in the last piece, which sort of overlaps the other two, is systems. Penny and I used to sell MMIS systems for fun, and it was very entertaining. What was interesting about it is that every state was buying one or two of these things, and they're not really all that terribly different. One of the things they all have in common is they're enormously expensive, and they take a long time to install. And we used to, quietly, over a glass of wine, wonder what would happen if CMS picked one or two and said to everybody, "Do you want federal match? Pick one of these two because they both will get the job done, and it will be a more efficient way to do it."

So I don't think that we've necessarily looked at some of the programmatic efficiencies, and yeah, you've got to have state flexibility, but it is taking that to an exerted level to say that Rhode Island and Delaware need to put in the same level of effort to install an MMIS that California and New York did.

CHAIR ROSENBAUM: Thank you. Brian.

COMMISSIONER BURWELL: So I have two quick

comments. The first comment is Penny's comment about backup quarterbacks does not hold true where I come from.

[Laughter.]

COMMISSIONER BURWELL: The second is I do agree with -- I mean, I just kind of build on what I think what a lot of other people are saying. What I think is kind of missing from these two chapters is the larger picture. We were talking about financing mechanisms, but at the end of the day, to me a financing mechanism is just a policy tool to achieve an objective, and if you're going to change the financing of the Medicaid program, the first discussion is, what do we want this program to be?

So the original -- when it was enacted, it had this financing mechanism, and that had a certain policy objective, which was mainly around access. We want to change how the program is financed, not only just kind of to introduce more of a cost containment emphasis in the program, but also changing the federal-state relationship. Those are two big changes. I think we have to have that policy discussion as a context for these two chapters.

CHAIR ROSENBAUM: Thank you. Sheldon.

COMMISSIONER RETCHIN: Just a quick point, and

maybe it builds on what Kit said. It is not a criticism because I think it's just wonderful work done from all of the staff on all three chapters.

But I went back to the first chapter, Figure 9, which shows all the state variations and costs, and I had a little hard time going from there, the last paragraph of Chapter 1, into the other two chapters, which jumped into the federal limits on spending. I can get it, but having neutral parties read this, I think a transition historically -- and maybe others -- have said that as well.

But as I look at that and then start to think about my experience in two different states as well, I'm struck by potential limitations of what states would be able to do in terms of if a block grant or some similar mechanism was imposed, would we be looking at unintended consequences like Chuck was describing, suddenly lopping off 10 days or looking at limitations of inpatient use, rather than spurring innovation.

So that gets me to my last point. While I appreciate the experimental nature of the 50 different programs that are ongoing, I wouldn't be ironclad sure that all the states in terms of abruptness, a very quick tempo,

would be equally innovative.

And I just call attention to the fact the rates at which managed care have been implemented in different states around the country have been extraordinarily different. We're 25, 30 years into the experiment, and still there are just huge variations, which you would think people would be getting to. Go from there to the demonstration on dually eligibles, which I think is a great experiment, but you would get to from the consequences of block grants to a very, very abrupt tempo to get innovations implemented in states that just don't have the infrastructure to do that.

CHAIR ROSENBAUM: Before I turn to public comment, I just want to take a second to sort of pull us together here. This was an incredibly rich and wonderful discussion. The draft chapters are strong. I think we had a lot of discussion about how we can further strengthen them, and that discussion really focuses on sort of thinking about going from patterns of spending to this fundamental aspect of the program, which is really how states spend.

And I think actually one of the things that I

always notice as I read chapters is that we don't use the word "state spending" enough. We talk about state match. It's really not a state match. It's really choices that states make and how they spend to meet program needs, population needs. They certainly can be incentivized, although as many of you have pointed out, less important than temporal financing incentives may be the sort of deeply felt issues of population health need, program need, efficiency need.

Then bringing up the point that the Medicaid statute itself, the federal/state, is a reflection of so many things, it's a reflection of lots and lots of complex requirements, some of which are very old and may merit a closer examination. It's a reflection of the gloss that has been put on the program over a half century by successions of administrations, not just the current one, but long, long-standing rules. If you read the departmental appeals board rulings, often they will cite back to a 40-year-old position taken by the agency.

And this question of what are you looking to do with the program, are you looking to modernize it, make it really a much better, more efficient functioning part of a

very, very big health care system that has repeatedly exhibited a dependence on Medicaid in so many ways and a need for Medicaid, or simply is your goal more narrow, which is to simply say funding, and that in itself, of course, is a policy statement. So I think it's this weaving, taking all the facts we lay out, and sort of weaving a story, so that by the time you are reading about a couple of distinctive approaches to federal financing, you are beginning to see it as part of a continuum of thinking about Medicaid.

So, with all of this great information now, I want to give the public a chance to comment and see if we have anybody who would like to make a comment.

PUBLIC COMMENT

* MR. CROSS-CALL: Hi. Jesse Cross-Call with the Center on Budget and Policy Priorities. I really appreciate this discussion today.

And so around the discussion about Medicaid's financing structure, I think that there are four points that I would like to draw out and consider. Some of these echo part of the discussion that's already taken place, particularly around block grants and per capita caps.

The first point is around the budgetary context for this discussion. Both of these proposals are explicitly designed to achieve federal deficit reduction and to achieve savings for the federal government, and switching to that kind of financing structure would naturally put a lot of downward pressure on the states, on the beneficiaries and providers.

The second point is that no matter how particular around the per capita cap you come up with a formula, the cuts to the program would likely be far larger than were originally anticipated.

So examples of this are if medical costs for a particular group rose higher than were anticipated. We saw this in the '80s with the HIV/AIDS epidemic when Medicaid was uniquely positioned to respond, but the cost for a particular group rose, very quickly, very fast.

The second is a demographic one. So we're going to see in the future years that among seniors, there's going to be a movement from a young-old age cohort to an old-old age cohort, and among the old-old age, they have more conditions. They are more likely to have disabilities, chronic conditions, long-term care needs,

which again Medicaid is there uniquely positioned to address.

And then the assumptions that would go into putting together the formula now about future spending growth, once you lock those in, it would be very hard to go back on them in the future, especially -- you know, you're making assumptions about whether the current health care slowdown -- or the health care spending slowdown is permanent, how it will change in future years, and it would be very hard to go back.

The third point is that some think that under a per capita cap, there are winners and losers among the states. It's much more likely that there are losers and bigger losers among states, so that's again to make the point that there's a tremendous pressure on state budgets if you were to move to an alternate financing structure.

And then the fourth point is to consider the Medicaid expansion and both the future take-up of the Medicaid expansion among states and then even in the states that have already expanded, if you were to change to an alternative financing structure.

So we have seen in states that there is a

tremendous worry about the federal government changing the financing structure and that some policymakers in states are worried that if they were changed that they would be -- that they would -- that this has deterred them so far from taking up the expansion. And then there are also states that have already expanded that are worried about the structure being changed in the future and have put safeguards in their legislation to repeal the expansion if the funding formula were changed in the future. So, potentially, this could affect the coverage for millions of people.

Thank you.

CHAIR ROSENBAUM: Thank you so much for coming.

Any other public comments?

[No response.]

CHAIR ROSENBAUM: All right. We stand adjourned until 1:15 when we reconvene.

* [Whereupon, at 12:03 p.m., the meeting was recessed, to reconvene at 1:15 p.m. this same day.]

AFTERNOON SESSION

[1:18 p.m.]

CHAIR ROSENBAUM: All right. We are reconvened here. Happy afternoon, everybody, and welcome back to the meeting.

So the afternoon is quite full. I want to get us going quickly, and the first issue that we will be addressing is the IMD exclusion. If we could have Sarah and Katie join us? Oh, there you are. You have joined us. Take it away.

THE MEDICAID INSTITUTION FOR MENTAL DISEASES (IMD) EXCLUSION

* MS. WEIDER: Great. So, today, Sarah and I will be presenting on the Medicaid Institution for Mental Diseases, the IMD exclusion.

So, on our first slide here, we present an overview of today's presentation. First, I'll start with a review of the past Commission's work related to behavioral health. Then we will discuss the definition of the Medicaid IMD exclusion, followed by the rationale for the exclusion, and changes of the exclusion since its enactment.

Then Sarah will pick up the rest of the presentation and discuss today's behavioral health delivery system, implications of the Medicaid IMD exclusion, proposals to modify the exclusion, and next steps. And as next steps, we are really seeking the Commission's input on this topic. Specifically, if there's an area in which the Commission would like additional research conducted and also if there is an interest in pursuing this topic further, staff can provide a more detailed analysis and criteria for policy options for an upcoming presentation.

So we started out past work on behavioral health with our June 2015 report to Congress that featured a chapter on the prevalence and expenditures of behavioral health conditions within the Medicaid program. From there, we began our work focusing on behavioral and physical health integration. At our September 2015 Commission meeting, we had a panel presentation discussing behavioral health integration in which we also highlighted our contractor catalog of behavioral health integration efforts within the Medicaid program.

That work led to our most recent chapter in our March 2016 report to Congress focused on behavioral and

physical health integration efforts in the Medicaid program. Within that chapter, we identified the IMD exclusion as a barrier to integration, and at our December 2015 Commission meeting, it was discussed that the Medicaid IMD exclusion was an area in which the Commission needed to do additional research.

So what is the Medicaid IMD exclusion? The Medicaid IMD exclusion prohibits federal financial participation, FFP, for inpatient psychiatric care provided in an IMD with more than 16 beds. Now, there are nuances to this definition regarding age of the individual and what kind of facility constitutes an IMD, but I'm going to get to that in an upcoming slide, so please hold your thoughts on that.

There are two major reasons why the Medicaid IMD exclusion was created and continues today. The first is a state role as a primary payer for inpatient behavioral health services. There was deliberate choice to keep funding of these services towards the states and away from the federal government.

And the second reason is a preference for community-based services and the movement towards treating

individuals in an institution towards a community-based setting. This began in the 1950s and continues today with the Olmstead decision and federal and state support of community-based services.

As I mentioned, there are specific age groups and types of institutions that fall outside of the Medicaid IMD exclusion. I'm going to walk through some of the major legislative and regulatory actions that narrow the Medicaid IMD exclusion's definition and scope, but first, let me point out that the original definition of the Medicaid IMD exclusion, which was included with the establishment of the Medicaid program in 1965, allowed an option for states to receive FFP for the provision of IMD services to individuals age 65 years of age and older.

Today, there are 45 states that cover IMD services through this option for adults 65 years of age and older. The Social Security Amendments of 1972 states the option to receive FFP for IMD services provided to individuals under the age of 21. This is commonly referred to as the "psych-under-21 benefit," and today, 38 states cover IMD services for children and youth under the age of 21.

Other changes were made to narrow the types of facilities included within the IMD exclusion. This includes the Medicare Catastrophic Act of 1988, which allowed states to receive FFP for the provision of inpatient psychiatric services provided in an IMD with 16 or fewer beds.

The types of facilities not affected by the IMD exclusion were then further expanded by the Omnibus Budget Reconciliation Act of 1990, which gave the Secretary the authority to provide FFP to states for inpatient psychiatric services provided in facilities other than hospitals to individuals under the age of 21. In 2001, CMS acted on this authority and established psychiatric residential treatment facilities, PRTFs, as an additional setting for which the psych-under-21 benefit can be provided.

So we see that through these changes, the Medicaid IMD exclusion mostly applies to individuals over the age of 21 and under the age of 65 who are patients in an IMD with more than 16 beds.

However, there are certain instances in which FFP is available for inpatient psychiatric services provided to

individuals over the age of 21 and under the age of 65. These include Section 1115 waivers. Maryland is currently pursuing an amendment to its 1115 waiver to receive FFP for services provided in an IMD. Additionally, California recently received approval of its 1115 waiver to receive FFP for substance abuse disorder services provided in an IMD.

Next, we have the Medicaid Emergency Psychiatric Demonstration, which was established through the Affordable Care Act. It permits Medicaid payment to participating private psychiatric facilities for the treatment of Medicaid beneficiaries over the age of 21 and under the age of 65. The demonstration currently includes 27 private psychiatric facilities across 11 states and the District of Columbia.

Another method of IMD payment is through Medicaid managed care. The proposed Medicaid managed care rule released in June 2015 clarifies that managed care plans can receive the full federal match on a monthly capitated payment for enrollees over the age of 21 and under the age of 65 who is a patient in an IMD. However, FFP for IMD-delivered services to these individuals is limited to only

15 days in a given month.

And, finally, as we know from our disproportionate share work, states can pay DSH payments to IMDs. Although there are limits in the amount of payment that can be made, this offer states another opportunity to pay for IMD services that are classified as uncompensated care.

Although we see there have been changes made to the IMD exclusion scope and there are methods of payment for IMD services, the Medicaid IMD exclusion has not adapted to the realities of today's behavioral health delivery system.

So now I am going to let Sarah discuss with you the current behavioral health delivery system, implications for the Medicaid IMD exclusion, and proposals to modify the IMD exclusion.

* MS. MELECKI: Thanks.

As Katie stated, today's behavioral health delivery system differs from that of 1965 when the IMD exclusion was first implemented with the creation of Medicaid. A current shortage of inpatient psychiatric beds has been indicated, both through anecdotal accounts of

behavioral health crises occurring when people can't find an open inpatient psych bed as well as through research showing that psychiatric boarding is a common practice in most emergency departments nationwide, and psych boarding occurs when a patient is in need of inpatient psychiatric services but remains in the emergency department for an extended period of time because the hospital can't find an available bed in a psych facility.

Today's system has also seen changes in medical practice and psychiatric facility conditions since 1965. Concerns such as lengths of stay lasting months or years, which is known as warehousing, as well as poor living standards and inappropriate treatment have become less likely.

By prohibiting federal financial participation for inpatient psychiatric services, the IMD exclusion creates a gap in the continuum of care. This can affect beneficiaries, states, and providers.

Implications for beneficiaries include difference in coverage for inpatient care based on age. As previously stated, states can choose to cover IMD services for children and youth under the age of 21 as well as for

adults age 65 and older.

Another implication is the potential conflict with EPSDT. Children covered by EPSDT are supposed to receive all medically necessary services that Medicaid can cover, but in states that don't provide the psych-under-21 benefit, Medicaid does not cover inpatient psych care in IMDs, and even in states that do provide the psych-under-21 benefit, some court cases have held that federal funds cannot be used for any services that aren't considered inpatient psych services to an IMD patient under the age of 65.

One unintended consequence of the exclusion for states is a limit on state's ability to target Section 1915(c), home- and community-based services waivers, to adults with behavioral health disorders. The limit can occur because a waiver enrollee must meet an institutional level of care need, but the waiver also requires cost neutrality. And since IMD services cannot be covered for adults under the age of 65, the cost of the services can't be used to prove cost neutrality.

Beyond 1915(c) waivers, states have sometimes found it difficult to identify to whom the IMD exclusion

applies. This has resulted in some states claiming improper federal Medicaid payments for IMD services, which must later be recouped by the federal government.

The IMD exclusion also has implications for providers. For example, the exclusion serves as a barrier to integrating physical and behavioral health as we learned from Maryland Medicaid Director Shannon McMahon during our Physical and Behavioral Health Integration Panel last September. Certain residential facilities, like long-term care facilities, may also be discouraged from accepting Medicaid enrollees with behavioral health diagnoses. These facilities can be classified as an IMD if 50 percent or more of their patients have a primary diagnosis of a behavioral health disorder in which case states will no longer be able to get federal funds for services provided to any of the facility's Medicaid-enrolled patients.

Another implication of the IMD exclusion is the encouragement of structural reorganization for larger inpatient facilities. Some of these larger facilities have been divided into smaller facilities for legal purposes, so that they will have 16 or fewer beds and thus not be considered IMDs.

And, finally, there has been an historic separation of substance use disorder treatment, also called SUD treatment, from other types of medical treatment, and because of this separation, SUD treatment facilities typically only serve individuals with a primary diagnosis of a substance use disorder. As a result, any of these facilities with more than 16 beds are considered IMDs, and CMS has recognized this as a barrier to providing inpatient SUD treatment services, and so last July, they issued guidance noting their willingness to approve Section 1115 demonstrations that include the ability to receive federal funds for SUD treatment services administered at IMDs.

Discussions about modifying the IMD exclusion have included a variety of ideas. While there are calls to either maintain the exclusion or completely repeal it, several other modifications have been proposed. The list on this slide includes some of the modifications that have been or are currently being proposed. There's more information on each of these modifications in your briefing paper.

So now that we have laid out a basic background of the Medicaid IMD exclusion, we look forward to hearing

your thoughts and ideas. Thanks.

CHAIR ROSENBAUM: So let's start the discussion. Obviously, what we need to think about is where would we as a Commission like to take this issue. What are the aspects of the IMD exclusion that merit particular attention, what do we want that attention to focus on, and how might it fit with some of the other themes from our work.

So, Andy, why don't you start us off.

COMMISSIONER COHEN: Thanks, and thanks for a great presentation.

So I think that I struggled with this, and I know it's very much a paper in development, but I think one of the issues is that it sort of starts with a proposal and then sort of goes backward to look at sort of arguments, pro and con, and we asked you to do that. But I think it's maybe not the best starting point for us on this issue because I think what is a little bit missing is what is the problem that we're trying to solve, and is this the solution for that problem? And, actually, there's clearly at least two sort of very different ones, one relating to substance use disorders and one relating to behavioral health, and many, many sub-issues. So I must say I was

just very challenged with the frame of it, which is the frame we asked you to take up, but I don't think it's the right place for the Commission. I don't think that's the right place for the Commission to sort of start this issue. So that's my kind of big-picture.

I had a few specific sort of issues and questions that I think could be addressed a little bit more in whatever the next iteration might be. One is there isn't much discussion, and it may be because it doesn't happen very often, but it is common practice in New York. There's lots of inpatient psychiatric services provided in general hospitals in some places, and there's no discussion of that.

So one of the questions is, if there is a lack of inpatient capacity, which there's not a lot of data on -- I mean, I did not think it was strong to start with an anecdote, but if that is the problem, one question I would have is why are IMDs necessarily the solution as opposed to other patient, inpatient facilities in general, in general hospitals. So that was one question, just there's no discussion of that issue.

The sort of argument about waivers, again, I kind

of thought it was a little bit twisted around. If the concern is that you want to promote more home- and community-based services and better sort of outpatient and ambulatory care kinds of services for patients who have behavioral health needs, the way to go about that isn't just sort of create a mechanism for a waiver, a cost neutrality, but it's to actually design that program more directly, statutorily, or otherwise.

And I think just sort of a last issue that really jumped out at me was sort of there is really this lack of data in the paper, and that may be because there is a lack of data. But I think it really fundamentally sort of limits our ability to tackle this problem and know if this is a solution that is really targeted to the problem we are trying to get at.

CHAIR ROSENBAUM: Okay. I have Kit and Toby and Sheldon. Oh, I'm sorry. Sheldon and Kit.

COMMISSIONER RETCHIN: Thanks for the presentation. I do think this is an area ripe for consideration by the Commission, and we've talked about it since I've been on the Commission. And I know it has a great history, and I thought that the narrative was

excellent.

But, like Andy, I guess one of the things that puzzled me is the different categories of psych inpatient availability, and I could only speak from more recent context in Ohio, where there is now a third party that every day tries to determine the availability of a bed because the inventory simply isn't enough. So there is not capacity, and per Andy's question, there's tremendous variation on this. But current general hospital or inpatient capacity, at least in the reasons that I've been in, is inadequate.

Moreover, what's happened over the last, I would say, 20 years has been a growth of the industry of IMDs, particularly in the investor-owned segment, which I think is a subtext in this. So while I think I do believe that we need more capacity and that reversal in some way, shape, or form of the IMD exclusion will help, it will be necessary but insufficient because then you'd be faced with -- the real issue is whether the IMDs will participate, particularly in managed care plans, and be willing to take these patients because they will have no emergency room, and they will have the option of non-PAR. While I think

opening up the capacity is necessary, I don't think it's efficient.

Moreover, I'll just say one more thing. With the growth of the suburban for-profit or investor-owned and maybe not-for-profit as well in the suburban locations, what's also happened is that some of the available inpatient psych capacity that was commercially reimbursed has now been siphoned off. So the mental health inpatient capacity in the inner city is now even worse off because the payment rates where there was cost sharing is completely ineffective now.

So, again, I think the IMD exclusion is a part of this, but it will not be the entire answer.

COMMISSIONER GORTON: So first let me state my bias, which is that during my time in government, I didn't start out in Medicaid. I started out on the behavioral health side, and spent eight years closing institutions. And it's really, really, really hard to close an institution, and a lot more of them need to be closed.

So, you know, I sort of come down with the advocates on this one. Anything that makes it easy for states to keep institutions open is something that I'm very

skeptical of at the outset and I think we need to take very, very seriously.

I guess what I would say with respect to the capacity issue is I find the data non-compelling. Are there high rates of ER boarding? Yes, there are. Are the inpatient census rates high and often over 100 percent? Yes, they are. But my experience of that, even in a place like now Boston -- and I've done this in multiple states, but in Boston now, it's hard to argue that Boston is under capacity for anything because we have got five of everything and six of some things.

And so is it that there aren't enough inpatient psych beds per capita in greater Boston? I think the answer to that is no when we compare -- yet they're full, and we have ER boarding and that's a problem.

And so what I struggle with -- and maybe this is work the Commission can do -- is nobody's looked at alternative hypotheses for why the beds are full and why there's ER boarding. I know in our health plan, we spend an awful lot of time with people on administrative days. They're ready for discharge, but there's nowhere to step them down to for their post-acute care. And some of the

issue is that the people who own that are the mental health authorities, and, you know, they're not moving people through.

So I think before -- I wouldn't want to jump to this as a solution for the ER boarding question and the inpatient census question. I would want to test the alternative hypothesis that what we have a throughput problem, and the issue is that we simply haven't -- while we've done a good job in building some community services in some communities -- and, you know, if you go to rural Appalachia in southwestern Virginia, there ain't a lot there. And so how do you get people out of the inpatient bed into the program that's going to step them down to the program that's going to step them down to the program? It's not just one step back to the community for many of these people. It's three or four or five steps. And the partial hospitalizations programs don't exist, and the day treatment programs don't exist.

And so, you know, it seems to me that we need to look at the whole ecosystem before we say, well, the reason we have ER boarding is because we don't have enough inpatient beds. So that's one issue.

A technical issue is I think you've got to be skeptical when you get confronted with these length of stay numbers, and, again, I think you need to deconstruct it a little bit. The short lengths of stay are the substance use disorder lengths of stay. A detox admission needs to take about 48 to 72 hours. And many of those people sign out AMA on the second day or whatever, right? So if you take that group of high volume churning through shorts lengths of stay and put it together with the people with serious and persistent mental illness, what you're going to find is that the mean may be low, but I think what you have is a bimodal distribution. And part of the issue is that if you're using claims data to inform your analysis, then all these administrative days that I and everybody else are denying, they're not in the claims data set.

And so, you know, I think we need to solve for how we get an accurate picture of how the ecosystem functions in its totality, and then we can sort of evaluate how it is that we can -- that we can solve for it. None of that to take away from some of the obvious problems that you've laid out that people have pointed to, but, you know, I would hate to see -- going back to my bias, I would hate

to see the good work over the last 20 years in terms of getting people out of inpatient beds be lost based on this. Andy said this better than I can. Maybe what we don't have is the right model of care. Maybe where somebody belongs is not in an inpatient bed but in some other crisis management solution that nobody has thought about yet because, quite frankly, it's far too easy to either leave them boarding in the emergency room until they finally aren't a problem anymore or to put them in an inpatient bed until, again, seven days go by and they're not a problem anymore. And I just don't know that we have had the level of technological innovation and treatment innovation for post-acute care that really serves the needs of the population.

Some have called out -- I was making fun of Governor Baker before. I'll give him credit now. He has been a leader in terms of talking about substance use disorder and that piece of it. And he was asked recently what he thought the federal government should do, and his answer was the federal government needs to invest more in funding research and innovation in mental health treatment and substance use treatment.

CHAIR ROSENBAUM: Thank you.

COMMISSIONER DOUGLAS: So good paper. I would really stress that we need to break it into two different issues: the substance use and the mental health. And I say that for a couple of reasons.

On the mental health, this has been something that we've been talking about for years, for a long, long time on the IMD, on the mental health side, and been a problem. And from a state perspective -- I come with a bias, too -- I'd say it's more of a financing issue. You know, it gets to we want federal funding.

So put that aside, I think the paper doesn't do enough on the substance use issue, and it kind of gets lost in it, and that concerns me for a couple of reasons. The substance use issue, when we talk about problems, is really a new problem that's come to the surface because of the Medicaid expansion. And with the Medicaid expansion, you're bringing in a lot of childless adults who are what we're seeing -- and I think Massachusetts is seeing this, and California is seeing it -- are ones with very complex behavioral health but primarily substance use issues. The ones with serious mental illness have been covering for

years under the disability and other areas. So it's a new problem that then goes to the continuum of substance use services around residential treatment, which isn't really, I wouldn't -- I just want to make sure, Kit, it's not just about the inpatient at a hospital, it's really about residential treatment and recovery. And the step down and the importance of the continuum of substance use services.

And so it is a -- you can't have the true continuum of services that have been set up for the non-Medicaid population -- you know, this has existed for a long time to have residential treatment -- that are more than beds. And so you're not going to have a continuum in the Medicaid space without it, which is why California -- why CMS is starting to see that they need to really test this out.

So it's a long way to say I think we've got to separate this out, got to give a little bit more strength -- not to say that we shouldn't be addressing the mental health side, here are the two sides, but I think the issue on the institutionalization and the concerns are not the same on the substance use side for the advocacy community because of the array of benefits and the importance of that

within the continuum on the substance use. And just mentioning -- of course, I'm biased, but mentioning that California -- in the paper that California did get the waiver approved, it's not just the notice that CMS put out about these options, but they've actually approved the waiver.

CHAIR ROSENBAUM: I must just add that I couldn't agree with you more, that I think this is one of these issues where we need to do -- and it's sort of coming up in the comments. We need to do some unpacking rather than deal with the IMD monolithically, which is so fraught and so historic and has all kinds of crazy effects -- and not so crazy effects. I mean, it sort of works in two ways. That what we might want to think about is selected issues where there is emerging evidence that an exclusion is having particular effects that may carry more downsides than upsides, where selected uses, you know, are worth thinking about, whether piloting or as a state flexibility option, which is sort of in keeping with how the world has come to, you know, come at this issue.

Just to repeal the IMD exclusion, you know, putting everything else aside, is so expensive that it's

sort of -- we don't even have to think about it that way because it's just absurdly expensive. So maybe we want to, you know, treat this one as more of a selective intervention rather than the whole.

COMMISSIONER MARTÍNEZ ROGERS: I'm going to agree with what Kit was saying earlier. One of the things that happened in the state of Texas with the institutionalization was that when the patients were released, the consumers were released, there were no community resources, and the community wasn't prepared to receive them. So what ended up happening is that we had an increase in homeless, an increase in jail population, because there weren't the community resources, and we continued to see this problem of increased homeless. You can just walk around Washington, D.C., and you see it. And a lot of it has to do with mental health and substance use disorders.

The thing about substance use disorders, which is my area of expertise in my field, is that it's hard to separate -- I mean, yes, you have the substance use disorder, but you also have the mental health issue. It's hard to separate that. And that's -- you know, something

happens. Yes, you get addicted, but the process of getting to that addiction is what? You know, so though I know that the treatment is -- it has to be together in terms of treatment.

The other point that I was going to say is: What happens in rural communities that don't have community resources? Like I've mentioned several times here, in South Texas, there are no mental health providers. So what happens, you have people who are just wandering around, who either end up going to jail, again being homeless. So there are a lot of issues, and I think that that needs to be incorporated in here somehow or another as to what happens when we don't have the funding for what it is that we do need.

COMMISSIONER MILLIGAN: The work has come a long way, so I think you guys have done a good job. I guess two quick comments.

The first is I think trying to tie together some of what Toby said and Kit said, the availability of financing for the institutional side actually makes it easier to finance the community-based side because of cost neutrality and other reasons. So I do think that that

point can be elaborated. In other words, having more tools with the IMD exclusion doesn't necessarily mean more institutionalization. It means more opportunities for cost-neutral, community-based solutions, because there is a benchmark on the facility side.

The second comment I guess I just want to make, and this is anecdotal, but I think one of the consequences of the IMD exclusion is that there are a lot of people in nursing facilities who have undiagnosed or underrepresented mental illness, and it becomes a different form of like the emergency boarding where it's not well -- you know, it's described as dementia or it's described as other things, but there's a very strong mental illness component that doesn't drive a care plan very well because it is a form of institutional stay.

So I think that there is -- again, it's anecdotal, but as more individuals with mental illness have longer life expectancies and age into more complex physical disabilities and more likelihood of nursing facility stays, I think that that kind of comorbidity gets masked partly by virtue of the IMD exclusion.

And I guess the last thing I'll say is I'm not

quite sure where our work goes from here. I think it may be just kind of descriptive of here's the situation and here's some options. And I think that that would be helpful in advancing the knowledge base about this.

So I'll stop there.

CHAIR ROSENBAUM: Yeah, I think that the more we can flesh out the origins of this, the drivers of it, the exceptions that have been drawn over the years, you know, it's okay to have a residential option for children, apparently, but not adults, I really don't ever quite understand why -- I mean, I know why, but in the vast scheme of things, it's sort of hard to answer -- that we have not made decisions very well around this for reasons other than financing expediency as opposed to looking at the evolving standards of treatment for certain kinds of conditions where, to the extent that this does exist in the evidence, there are situations where having a residential component to treatment, even for a short period of time, may play a critical role in the treatment efficacy.

To the extent that we can pull that kind of information for policymakers, it sort of takes us in a different pathway from the origins of this, which were just

like prisons, I mean, just the federal government saying we're not federalizing these expenditures. And, of course, there was also the concern about warehousing, but I always have thought of this more like prisons than concerns about well-being, because it's so old, in fact, the exclusion. In many ways sort of at the birth of the institutionalization movement, this was still -- you know, this existed even before that.

So I think maybe trying to shape the chapter around where have we made selected incursions on substance use disorders for children in certain kinds of pilot testing arrangements and what do these incursions tell us and what does the evidence on evolving norms of treatment for certain specific kinds of conditions tell us might be a better way to move the chapter along.

The other thing I would add to the list of problems that the IMD exclusion has always triggered is that while it is only a -- I mean, it's really a coverage and payment exclusion. It has been treated often as an eligibility termination, and very incorrectly, a lot of states have terminated eligibility for people, and then there has been this desperate scramble to try and get them

back onto the program as opposed to simply suspending payments for certain kinds of treatments and benefits.

So, I mean, there's a lot of reasons why an exclusion is a blunt instrument and why it has created problems along the way and maybe being -- showing how we've evolved beyond this blunt instrument to try and use the best knowledge now to come back a little bit from this brink and what the future directions are I think would be a real contribution.

COMMISSIONER RETCHIN: Yeah, I just want to get back to, I guess, the point I was making that -- and maybe it still has to be -- the entire approach has to be -- maybe there's more information here in terms of the IMD growth. But there has been a -- it's not that there hasn't been a growth in or at least a sustenance of availability of beds. It's just that the beds aren't available for certain kinds of patients, specifically Medicaid. So if you go down to an emergency room today and you have a commercially insured patient, you'll have no problems finding a bed. It's the Medicaid inner-city patient. And, you know, with all due respect, if you really go down there and see, these are patients who are desperately ill, and no

outpatient service is going to really take care of a patient like this who has raging schizophrenia and is suicidal.

I think that parity, again, as I said, a reversal of the IMD exclusion won't take care of this, but thanks.

COMMISSIONER THOMPSON: I just want to make one more point -- and great conversation -- about the provision in CMS' NPRM with respect to the 15-day allotment, if you will, of days. Interestingly, if you read some of the comments to that rule, as often happens, CMS thought that it was loosening up on a provision that it turns out some people were interpreting in such a way that the clarification will actually tighten. So some plans and some states in a generous way interpreted the in lieu of authority to say that basically any plan could make any decision to substitute any service at any time for anything that it felt could more effectively meet the needs of the beneficiary than the particular service that might have been covered under a state plan, including IMD services.

So it's going to be -- I just think that we should keep our eye on both what the finalization of that rule looks like, what any potential transition policies

look like to reflect the fact that some people said, hey, we do a lot more than that now, and maybe also try to see if there isn't some way for us to collect some early data or some early feedback on experiences for services delivered to people under that in lieu of provision inside of plans.

CHAIR ROSENBAUM: Thank you very much.

All right. We are set to go with our future of CHIP discussion.

THE FUTURE OF CHILDREN'S COVERAGE: REVIEW AND DISCUSSION OF POLICY OPTIONS

* MS. JEE: Good afternoon, Commissioners. Today, we are returning to the options for coverage for low- and moderate-income children.

As you recall, during the January meeting, we touched on five broad options for children's coverage moving forward. We also took some time to review key findings from the Commission's analyses on what would happen if CHIP funding were not renewed. That included a discussion of what would happen to coverage and uninsurance rates, affordability of coverage, and adequacy of benefits. We touched on provider networks as well as transitions in

sources of coverage. We also discussed how Medicaid expansion CHIP would be affected differently than separate CHIP.

So, today, we do want to return to those options so that we can take a closer look at them. The objective for today is to narrow down to a smaller set of options which will be the subject for your further consideration. To do that, we will quickly go over some criteria for assessing the options and then run through the options themselves, describing what those options could look like and what we know about them relative to the criteria. Finally, we will review next steps and talk a little bit about the work that lies ahead.

So, moving on to the criteria, this slide shows some criteria for assessing the options, and these are criteria that, Commissioners, you have identified over the course of your discussions on children's coverage.

The first column here on this table just lists what those criteria are, and then next to them, we've highlighted just a top line consideration for you as you assess the options relative to the criteria. As you think about them, the options and the criteria, you may find that

there are trade-offs between some of the options, because how the options satisfy the criteria will vary based on the design of the option. Your discussion of the options will help in setting the rationale for any recommendation that may emerge.

So, to just quickly go through the list of criteria, the first is coverage. How does the option affect coverage for the low- and moderate-income children it would cover and what would the eligibility levels be?

Second is affordability. Under the option, is coverage for children who are low- and moderate-income affordable, and what might the benchmark for affordability be?

Next is adequacy of benefits. Do the benefits provided under the option meet the needs of covered children, and what about children who have high health care needs? Would any benefits be required? And is there a benchmark for the benefits?

Next is impact on states and state flexibility. How much state flexibility is afforded under the option, and what does that mean for any resulting variation? How much uniformity would be required under the option?

Next is federal and state spending, which is pretty self-explanatory. But, how much does the option cost for both the federal and the state governments?

And lastly is simplicity. This is something that has come up at previous meetings in terms of program design and administration for both the federal and state governments as well as for the families who will be using the coverage under the option.

So, that's just a quick overview. There are a little bit -- there are some more details for you in your meeting materials.

I'm going to turn it over to Chris. He's going to run through each of the five options in the context of each of these criteria.

* MR. PETERSON: Thanks, Joanne.

So, for each of the five options, we have two slides. The first gives an overview of the option and some of the overarching effects, and then the second slide explores the option in terms of each of the criteria Joanne mentioned. Of course, there's not enough room on the slide to go into the detail that's in your Commissioners' Memo, but hopefully, this is adequate for your discussion.

I also want to make you aware, we'll be making two kinds of comparisons as we look at these options. Sometimes we'll be comparing an option to no CHIP, because under current law, that's what happens in 2018. Plus, that is for the most part how the Congressional Budget Office will assess the impact of any changes that are enacted.

Sometimes, though, we want to compare an option to CHIP continuing, and so that way, we can distinguish between two scenarios of, yes, this option would cover more kids than under current law if CHIP ended, but on the other hand, it doesn't cover as many kids as CHIP does now. So, just wanted to give you a heads up that that's how we'll be proceeding here.

So, option one is to maintain current law. This is what will happen if no action is taken regarding the future of CHIP or children's coverage, so that means no CHIP allotments after 2017. States are going to exhaust their federal CHIP funds in fiscal year 2018. CHIP as we know it would end. As we've talked about before, the impact is going to depend on the extent to which states have separate CHIP programs versus Medicaid expansion CHIP programs.

For separate CHIP, our latest estimates -- so these are new estimates for fiscal year 2018 -- is that separate CHIP coverage would end for 4.2 million children, of whom 1.5 million would become uninsured.

And then we have the other enrollees who would be in Medicaid expansion CHIP. Their coverage must be maintained through fiscal year 2019, although once CHIP funding is exhausted, then that would be matched at the lower Medicaid matching rate relative to CHIP.

And, another thing to keep in mind is that the maintenance of effort, then, ends in October 2019 and states could roll back their coverage in Medicaid to 138 percent of poverty.

So, looking in a little more detail about what the potential effects are, under current law, of course, as I mentioned, it's going to -- the coverage is going to vary by state depending on the extent to which they use separate CHIP versus Medicaid expansion. But, of course, as I mentioned, there will be an increase nationally in uninsurance.

Affordability, we talked about this in the March report, of course. We found that out-of-pocket spending

would be higher for these children in subsidized exchange coverage and in ESI compared to CHIP.

On the benefits side of things, we know that major -- most major medical benefits are covered in separate CHIP as well as in exchange and employer-sponsored coverage, but it's in pediatric dental and some other benefits that will be different compared to CHIP.

In terms of impact on states, of course, no separate CHIP for them to have to administer under current law, but they would still have to make these transitions take place as they would close down their separate CHIP programs. Again, on the other hand, the Medicaid expansion CHIP programs must continue.

On the federal and state spending side, of course, without CHIP, that means the federal government would be spending less money for those children. The state spending effects are going to vary. Again, this is where it varies by separate CHIP versus Medicaid expansion CHIP, because if separate CHIP ends, these states are no longer required to pay anything. But if they're Medicaid expansion CHIP, they must continue that coverage at a lower matching rate. So, for those states, spending actually

increases.

On the simplicity side of things, you know, from the 100,000 foot level, there is one less coverage source in the continuum to have to think about, but for affected families, they go from needing to move from separate CHIP and having to compare employer-sponsored, exchange coverage, and consider those options.

COMMISSIONER RETCHIN: Can I ask a technical question?

CHAIR ROSENBAUM: Yes.

COMMISSIONER RETCHIN: Could you go back. So, the estimate is that 4.2 million children would be -- CHIP coverage ends on 1.5. What is the source of insurance for the others who maintain some source of insurance?

MR. PETERSON: It would go to employer-sponsored coverage or exchange coverage, and the estimates -- just so I can have it -- 1.6 million would go to employer-sponsored coverage and 1.2 million would go to subsidized exchange coverage.

VICE CHAIR GOLD: [Off microphone.] It's in page seven of the text, the memo.

MR. PETERSON: So, then, going to extending CHIP,

if federal CHIP funding is extended, of course, then it continues in its current form, but as with the Commission's recommendation to extend coverage, CHIP, by two years, also have to think about the maintenance of effort and the 23 percentage point bump in the CHIP matching rate, what to do about that.

And, the potential effects. CHIP would continue, so that means that coverage continues. The rules continue in terms of affordability and benefits and whatever flexibility states currently have. And then federal spending would increase relative to current law.

And in terms of simplicity, there would be no disruptions from the loss of CHIP coverage. On the other hand, though, one of the Commission's concerns has been about the cliffs between sources of coverage and that would go unchanged if CHIP were simply extended.

All right. Option three has to do with the bridge option, and let me just say at the outset here, we have not until now talked in great detail about what a bridge option might look like. So, we have crafted the description here based on prior Commission discussions, particularly from the session at the December meeting on

premium assistance. And, as a reminder, premium assistance is the ability of Medicaid and CHIP to pay for the premiums and cost sharing for private coverage, generally employer-sponsored coverage, but in some cases and now growing, as Joanne had talked about, now also non-group coverage, including exchange coverage.

And, although it has been rather difficult for states to implement premium assistance for employer-sponsored insurance, it could be somewhat easier to implement premium assistance for exchange plans because there's standardization in cost sharing, for example.

So, that's the notion we were trying to build on here for the bridge option. So, Commissioners, as I go through this, you may have had something entirely different in mind, so please let us know. Our intent by beginning this way is simply to give you something concrete to react to and to begin a discussion. So, this is for you to tailor at will. But, the idea that we've laid out here is that under this, the federal CHIP funding is extended. The CHIP program continues. But, in addition, states would have a new option to use CHIP funding to bridge Medicaid and exchange coverage by purchasing exchange coverage with

CHIP funds. So, that would be a new explicit state option.

Design parameters to consider. Eligibility -- is this only for children who are currently eligible for CHIP or would there be the opportunity for states to expand eligibility?

Affordability standard. Most states are actually charging premiums and cost sharing that is below five percent of income, so is the new bridge option in the state going to align with exactly what's in the state or can it go up to a five percent of income max, as in the CHIP statute, or maybe even higher?

Another question would be whether to make this new premium assistance option available and align with employer-sponsored insurance.

And, finally, as with the extension of CHIP generally, would have to think about a maintenance of effort in the matching rate and what to do about that.

CHAIR ROSENBAUM: So, just a point of clarification. This would be essentially, as you note in your title, a building up of state flexibility under the CHIP authority. So, things that may be purchasing options that are not there today would be added. A state could

maintain a classic separately administered CHIP program. It could maintain a Medicaid expansion CHIP program. It could do a combination of the two. Or, it could use its money to essentially strengthen exchange coverage or employer coverage.

MR. PETERSON: Correct.

CHAIR ROSENBAUM: So, it's adding to the menu for states.

MR. PETERSON: Exactly.

COMMISSIONER THOMPSON: So, that -- I'm sorry, just that third option is basically a premium assistance program with a wrap.

CHAIR ROSENBAUM: Yeah, supplemental financing beyond what you would get from your tax credits.

COMMISSIONER THOMPSON: Okay.

MR. PETERSON: So, just to go through the table here, again, with CHIP funding continuing, then that all stays the same for those eight million children. Then the question is, would more children be eligible based on how you would design this particular option.

Same with affordability. Current CHIP rules continue, but on the bridge side, what would be the

affordability standard?

Same kind of discussion around benefits. CHIP continues, but what would be permitted on the bridge side?

And current state flexibilities under CHIP would continue, plus there would be additional flexibilities under a bridge option, but with that might come additional requirements, as well.

We don't know exactly what federal spending would look like. It would increase relative to current law to be at least whatever a CHIP extension would cost, but then there are issues of, well, if you expand eligibility, then that could mean additional money, so design matters there, as well.

On the simplicity side, no disruptions from a loss of CHIP funding, but enrollees and families would have to think about having to deal with this bridge option and what they would want to do in deciding.

So, there's that one.

Number four would be to enhance exchange coverage, and under this option as we've laid it out, CHIP funding would expire as under current law, but exchange coverage would be enhanced to improve coverage and

affordability and benefits.

So, there are multiple ways that one could go about this. One is to address the family glitch, which is under current law, if you are eligible for employer-sponsored coverage, you are generally ineligible for exchange subsidies, and the exception is if that employer-sponsored coverage is not affordable, and that is based on your out-of-pocket premium for that coverage is 9.66 percent of your income. But, that only applies for self-only coverage. The cost of family coverage is not counted. So, that's why some have called it the family glitch. We're just using the shorthand term here.

And our analysis has shown that just by fixing the family glitch actually doesn't change uninsurance all that much, because they still have to pay out of pocket whatever is required in exchange coverage, and so the analysis for kids doesn't change the situation.

CHAIR ROSENBAUM: And again, just to clarify, I assume that four could be a dogleg off of three. In other words, you could nest into state CHIP flexibility the ability to use your CHIP funds to essentially mitigate the effects of the family glitch which happen today.

Toby, did you have a question?

COMMISSIONER DOUGLAS: Well, I was trying to understand three. So, does three right now address the family glitch or it would be what Sara is saying?

MR. PETERSON: I think that is up for you to decide. In other words, option three is, at a minimum, extend CHIP as is and all the kids who are there, states would have the option to say, hey, these kids are eligible for CHIP. We want to put them in exchange coverage and we will pay for it and we will, as Penny said, wrap around it.

The second order question is, does this go higher up the income scale? Could states expand eligibility? And in that case, it could start to get at the children who are in that income range who are not now eligible for CHIP, but who are also not eligible for exchange coverage because of the family glitch.

CHAIR ROSENBAUM: I think we'll come back to this --

COMMISSIONER DOUGLAS: Yeah --

CHAIR ROSENBAUM: -- but the answer is, you could see the connection between two, three, and four. Two is a straight-up expansion, just status quo. Two-A, being

number three, we add a few flourishes. And four being like 2-B, we, add a few more flourishes.

VICE CHAIR GOLD: But, couldn't four also come under one?

CHAIR ROSENBAUM: You could put it under one. You could decide to fix the family glitch and let CHIP die. Absolutely.

EXECUTIVE DIRECTOR SCHWARTZ: So, you're going to narrow this --

CHAIR ROSENBAUM: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: -- by renaming these all as one option.

[Laughter.]

CHAIR ROSENBAUM: I was thinking that, but --

EXECUTIVE DIRECTOR SCHWARTZ: Thanks a lot.

[Laughter.]

CHAIR ROSENBAUM: So, we should -- I mean, Chris is doing this exactly the right way and we should let him finish and then decide how we're going to put the pieces together and what we can take off the table, which is probably at least one item, so --

MR. PETERSON: All right. And just to finish up

on this slide, so the issue with just fixing the family glitch, as I said, it's still an affordability challenge. So you can take extra steps to make exchange premiums and cost sharing lower.

So, again, on this side, what happens on all of these things really depends on what you would decide, how far you would want to go in enhancing that exchange coverage, who is eligible, how much are they going to pay, what are the benefits that are covered, how different is it going to look from what's out there now.

And then the final option, Option 5, is to expand mandatory Medicaid. Again, let CHIP funding expire, as under current law, and in its place extent Medicaid up to some level. And, again, you would have to think about the matching rates, right? So if you make a new, a bigger group of mandatory Medicaid children, do you increase the matching rate for states in that case? And then what about the states who had already expanded Medicaid to those levels?

Same here, how far up the income scale would one go for such a Medicaid expansion, and then the other thing you would have to recognize is wherever you stop going up

the income scale, children who are now in CHIP who wouldn't be covered by that Medicaid expansion now, they'd go as would occur under current law, which is employer-sponsored coverage, exchange coverage, or uninsurance.

And so affordability for the children who would be newly eligible for Medicaid is going to be at least as good as CHIP, but for the other children losing CHIP who are above wherever that Medicaid line is, then it would be similar to current law.

The same thing with benefits, those who are covered by Medicaid would get the Medicaid benefit, and the others would not. And so you can see here that spending depends on the federal matching rates, and that kind of completes this slide.

I'm trying to rush through so I can give time for your discussion.

So, for this, this isn't on the slide, but I'll just say for this session, our goal is for you to take off options based on what you think is not desirable, not tenable, doesn't align with your criteria that Joanne presented, and then hopefully, we can narrow it down to the one mushed option or however that may be, one or two or

however many you want us to come back with.

So we want to hear on what you think remains, what the possible design parameters would be, and then with that, as you see on the slide here, we can come back at the May meeting and iterate with you on those parameters and the effects of different sub-options to lead toward a recommendation in December.

CHAIR ROSENBAUM: The only other thing I would add just as a little footnote is that on No. 2, which is essentially the status quo on CHIP, we probably will want to talk about the existing Medicaid maintenance of effort as a flourish on the status quo or not. In other words, you could imagine having a status quo approach that includes both continuation of funding for CHIP and holding the maintenance of effort for children as it exists now beyond as well, if we decide to go further.

All right. There are several people who were particularly focused on these options in preparation for the meeting. I do want to start with Alan Weil, because I know you are going to have to leave maybe a little bit early, just to get your thoughts, and then if we could turn to Andy, Peter, Sharon, Leanna, and Norma.

COMMISSIONER WEIL: Well, depending on how quickly we all are, I should be able to be through all of those, but thank you for giving me the opportunity to go first.

Well, first of all, I want to take Anne up on the offer. We will narrow this by calling them Options 1A, 1B, 1C, and 1D, and there's only one option.

[Laughter.]

COMMISSIONER WEIL: Forgive me. I'm going to play a little bit of historian. I know a number of you could do the same, but I really think thinking about options requires going back to why we have the options we have and what problems we were trying to solve, some of the discussions we actually had around the IMD exclusion.

So when I think about the creation and the bipartisan and federal, state popularity of the program, much of it is tied to the fact that states have flexibility on the methods they could use to expand coverage to kids, obviously the high-profile choice of Medicaid versus a separate state, the absence of an entitlement, flexibility around benefits, cost sharing, and the like.

And, fundamentally, I think if we undercut that

general principle of flexibility, we're going to have a whole new set of problems on our hands, and we don't want to do that.

At the same time, the goal was to reduce the number of children without health insurance, and the context for parents was totally different at the time of enactment than it is now. And I think the question for me is, how do you modernize -- also, our understanding of the best benefits for kids has evolved, but how do you modernize a program where, frankly, a lot of those kids had uninsured parents? And still many do, but now we have Medicaid expansion. We have CHIP being used to cover parents, but we now have the exchanges. We now have an employer mandate and an individual mandate.

So, in the long run, the notion that CHIP sort of remains as this totally separate program for kids seems sub-optimal. It seems unduly complex for families, unduly complex for states. That's probably not the way to go. But as you all decided before I joined the Commission just the beginning of this year, letting program expire is also not a good option. I'm happy to take that one off the table really fast.

To take the notion of hybrid options to heart, where I start is we need to preserve the flexibility for approaches, but what we have to caution ourselves against -- and I think of this both substantively and politically -- is that we're not just giving states another pass. Two more years, and after that, we'll give you two more years, and we'll give you two more years after that, because at some point, we have to have a future state in mind. And if we're going to open up new options, I think those options need to be viewed in the context of progress toward a viable future state, and so the risk I think that arises in separating out these options is that if we, for example -- and I'll focus primarily on Option 3 -- create an optional bridge, the question is, is that bridge being created with an eye toward a long-term holistic approach to family coverage with the appropriate benefit package for children, regardless of which coverage source the parents have, in which case I can get really excited about the bridge, or is it fundamentally a financial bridge, which says, "We don't want to pull the rug out from under states. We don't want to have a bunch of people lose coverage. We're not prepared to make other things mandatory. So we'll let you

do this"? But if that's sort of a freestanding additional option, it seems to me it adds complexity rather than reduces it, and it fails to lead us to a place where we have some confidence that after this two-year fix, we're not asking for another two, another two after that.

So where I come down is I think we have to start with sort of first principles. Some of the technical questions that just came up, we could spend a lot of time on, but since today's goal is really narrowing, it does seem to me that we've learned a lot about what appropriate types of coverage are for kids. We now have a different environment of where parents get coverage than we did when the program was enacted. We need to build not just a single bridge, but we need to be building the infrastructure that gives states options to incorporate children's coverage into a family where the parents have Medicaid, into a family where the parents have exchange coverage, where they have employer coverage, and hopefully a shrinking number of those that are uninsured. And to me, that's not just proliferation of options for states. It's options for states as they embrace a direction.

So I am kind of inclined to stop there because I

really want to hear other people's take on the specific options in which to take off the table, but just from the perspective of sort of principles for how to think about the options and to collapse them, I want to make sure that we're not just creating new options. We're creating options that are directionally appropriate to what an integrated family coverage looks like in the future.

CHAIR ROSENBAUM: So just to pick up on your point and then we'll move on, what I hear you saying is that as we think about making progress and reducing the number of uninsured children, we want to make sure that the CHIP tools that are created for states lets them essentially mold a children's coverage policy based on the market conditions, the conditions of their states, and this issue of differences among states and differences in the coverage environments is one we need to keep in mind.

COMMISSIONER WEIL: Yeah. And I'll be even more blunt. I very much like the way you said that. I mean, a state that gets excited about wrapping around exchange coverage, but then sort of ignores the fact that there are going to be a lot of kids whose parents have commercial coverage, which, you know, depending on where they get it

is going to have some differences and similarities to exchange coverage and sort of doesn't take on the issue of how to make that work, that's what I worry about is sort of getting excited about the new option because now we have these exchanges. We're trying to figure out the new option, but not attending to all of the options.

CHAIR ROSENBAUM: Why don't we move to Andy.

COMMISSIONER COHEN: Great. I will borrow much of what Alan said because he said it so well.

So I want to take us back for a second and say since I have been here for a long time, we have really come a long way in this discussion. I think you have laid out the options and the criteria really nicely and as clearly as humanly possible, considering some things are not clear. So I really applaud you on that, and I do feel like we are making progress.

I'm sort of trying to figure out what's the most productive way for me to provide my comments after Alan kind of got to the heart of the matter, but I think I maybe just want to say a couple of things. I think I'm just going to take a shot, if it's okay, at kind of going through a little bit the criteria and just sort of putting

out a straw man of where I think we might be on some of them, and that they're only for discussion, but I think maybe it will help our conversation a little bit and help sort of explain why some people might want to throw out one option. You might disagree with me and throw out others.

We've talked a lot, and we've learned a lot based on your analysis, very original analysis about the effects on coverage of doing different things, and I do think underneath all of that all along at MACPAC, there has been a fairly commonly held perspective that you can test me on, that significant drops in coverage for children as a result of this transition is not acceptable. Anything that is going to result in sort of meaningful net losses in coverage for children is not going to be an option that we will want to pursue as a recommendation in the first instance. So I throw that out there for one. I think some people might say any loss of coverage, but I am going to make it a little bit broader than that, that anything meaningful.

In terms of affordability, I think that we have learned, again, done a lot of analysis and reviewed a lot of literature, and I will throw out I think there is a

general sense that affordability for children, appropriate affordability may look different than affordability for general adult populations, number one. Number two, that affordability can't be done on a child-by-child basis, but has to be done on a family basis. Number two, since many families have multiple children, and so I'll sort of leave those as maybe some basic things.

On benefits, I think we learned that there is not a tremendous -- there is not a clear amount of difference between benefits in a CHIP and the exchange, meaning we cannot identify major areas of difference. There's definitely one with respect to dental.

I am a little bit afraid that we are sort of setting CHIP benefits as like our ceiling, and they're not as good as Medicaid benefits. And it was a process for looking at essential health benefits across the board, and I don't think that we want to sort of let that process for kids sort of go by without paying attention. Time goes on, benefit may change, appropriateness may change, and so I just caution a little bit about thinking about the CHIP benefits as a sort of ceiling or that we don't need to think about benefits just because exchange and CHIP

benefits don't look terribly different in nature, in categories other than, to some extent, on dental.

And then there's the issues of state flexibility versus -- you know, I think we sort of are in different places on the issues of state flexibility versus standardizing something, nationally. I am feeling like there is something like a national program. I think the issue of sort of who decides which is not a criteria, but maybe kind of goes to the difference of Options 2, 3, and 4, a little bit of is where does the decision lie in terms of setting standards, and who decides where the options for bridging money and things may be, I think that that's maybe almost a separate criteria.

And then I think the last -- so, in terms of spending, I don't think we have come to any general conclusions, and on simplicity, I think we have said for a long time in this Commission that that is an important issue for us. I would say I think we could go a little bit deeper and explore it. When we say simplicity, simplicity for who? I would say a sort of person-centered, sort of member-centered simplicity is the most important thing. I am a little less concerned if it's complicated for the

bureaucracy, although that's not irrelevant by any stretch. But I just want to put that out there.

So that's sort of like an initial take that anybody can tear apart on kind of where we are, and with that, I would say a couple of things. I agree with Alan. I think maintaining current law falls off the table because it just simply doesn't meet the coverage criteria that I --

CHAIR ROSENBAUM: You mean let CHIP expire.

COMMISSIONER COHEN: Yeah, exactly. Exactly. Too many children would lose coverage, and I just don't think that we want to seriously entertain that as our recommendation, or at least I don't.

And with that, I want to just sort of reiterate Alan's comments. He said it very well. I think the Option 3, this hybrid option, is a very attractive option and one that definitely needs to be developed in a number of ways, but this idea that you could think about CHIP as a program and a financing source for uniquely children's coverage, but doing it in the context of other sort of coverage platforms that their families are already in is a very attractive notion, and I really do like the sort of structural piece of this that we haven't talked about quite

so much. But CHIP has been a focal point for children's coverage, even though it covers a very small number of children relative to Medicaid and employer-sponsored insurance.

I do think having a program that is a focal point for thinking about children's coverage is something that is a very positive thing, and I hate to lose it. But, on the other hand, I think having a long-term vision that thinks about that program as making other platforms for coverage more appropriate for children is a really creative and positive way to go.

So I will stop there. I know I took a long time.

CHAIR ROSENBAUM: Well, let me just do something impromptu before we turn to Peter, and that is we can't help but notice that lots of children's advocacy groups and groups focused on children are here. So what I'd like to do is instead of having you all wait until 4:30 when you probably will have drifted away, we are going to try and stop our commentary period a little bit short, let you all do a public comment closer to three o'clock, 3:05, so that we're not holding you here for another two hours.

So, Commissioners, as you go around, to the

extent that you can be additive where we need to add or brief on a point so that we can move through all of us and then let people in the audience also speak.

Toby, I will add you to the list. So let's go to Peter.

COMMISSIONER SZILAGYI: Yeah. I will be very brief. I totally agree with Alan and Andy. Maybe a couple of additional points.

In a nation where few people -- where there is so much disagreement on so many important topics, I find that children's coverage is one area where we do converge and we can agree in a number of different ways. One is kind of the ethics of covering all children. Another is that it's a good thing that we're almost there, that there are 22 states where we're very close to covering all children, and a third is that the evidence is pretty clear that people have studied CHIP. And there is a marked improvement in access, quality, and some health outcomes for kids who get health insurance. You've heard me say that before, and I just wanted to repeat it. We often lack evidence in a lot of children's health care, but this is one area where we do have evidence. So, to me, Option 1 has to be off the

table, just stopping CHIP.

From my own metric, any option where any children lose coverage in my metric is unacceptable, and a situation where we have good evidence it's not an expensive program. It works, and there is a lot of agreement. So, in my mind, any option where any children lose coverage is not acceptable. So that's a little bit of a different flavor from what Andy said.

Another point I want to make -- and I'll try to make just new points -- there is a lot of evidence that children who live between 200 and 300 percent of the poverty level have a tremendous number of unmet needs and are often not that different than children between 100 and 200 percent of the poverty level. So trying to create cutoffs at sort of 200 percent, it's somewhat artificial to me. It's not a dose response by poverty, and many studies that have looked at this have found that it's more like around 400 percent of the poverty level where you get somewhat of a decrease in unmet needs or major problems.

So I would have a difficult time in any option where the cutoff is as low as something like 200 percent. I know lots of states have experimented above this.

I do want to really support what Alan started off saying, that the state flexibility and the methods and the design really has been a linchpin of CHIP, and I think we need to -- this is a greater area where we should try to maintain flexibility. And I do like Option 3 because children wouldn't lose coverage, and it would allow the flexibility to build into the exchange component.

And one last point is, as Andy said, I think this is a great opportunity to start thinking about what do children need way beyond CHIP, that a standard benefit package is possible, and at the same time allows states flexibility in how they roll it out. I think certain parameters around children's health care that are national is possible and maintain state flexibility at the same time. That may be much more difficult in many other areas in health care, but I think that is possible in child health care.

CHAIR ROSENBAUM: Thank you, Peter.

COMMISSIONER CARTE: Thank you.

CHAIR ROSENBAUM: Is your mic on, Sharon?

COMMISSIONER CARTE: Yeah. Sorry, I'm not that close.

I think, like some of the others, my attention goes mostly to Option 3 as where we need to focus our attention. And even though, you know, I was quickly able to rule out Option 1 and Option 5, I would like to say that I think along the lines of state flexibility that we might want to cost out what it would take for each state to go to 150 percent FPL for Medicaid for children just because we still have a stairstep effect there in many states. I still don't think it's helpful for families to end up with one child in CHIP and one -- or one child in Medicaid or CHIP or someplace else. I think it could also be part of states' flexibility to build that in as an affordability protection for low-income families.

But we still do have to focus on what would make an acceptable exchange, robust pediatric benefit, and there I think it might be helpful to define parameters in relation to the CHIP program, the average benchmark, using it as an average benchmark but maybe look at 100 percent actuarial value and 95 percent in the 90.

CHAIR ROSENBAUM: Sorry. So what you are saying is that to the extent that we favor giving states an option to essentially lift -- both lift the actuarial value of the

exchange pediatric benefit and also potentially overcome the family glitch using these funds, that you would like to see some attention paid to the level of lift that we would expect?

COMMISSIONER CARTE: Exactly, yeah, and to see what it takes -- I think of it as having -- defining like a close coverage equivalence, I guess, for anything that's in the exchange.

CHAIR ROSENBAUM: Great.

COMMISSIONER GEORGE: I kind of also lean toward Option 3, but as a parent, I do have some concerns. I'm really concerned about the out-of-pocket expense part because if I'm paying $25 each time my child goes to the doctor's visit for a regular routine visit and we go seven times a year for one child, six times a year for the other, that adds up, and that's before getting the medications and things like that. Of course, the one child's on Medicaid, but that's a different story. But many families have multiple children in their households.

The benefit, though, is that what we're spending on my child also applies toward our family deductible for either the exchange or the corresponding health care we

have.

I was already thinking along what Sharon had suggested about possibly seeing if we can bump Medicaid up to about 150 to help cover those that the $25 office visits would be really, you know, hard on. But that was kind of my thoughts on the whole process there.

CHAIR ROSENBAUM: Thank you.

COMMISSIONER DOUGLAS: Just to add on in terms of Option 3, definitely the state flexibility is a huge plus. The concern or just issue that I think we really need to explore is around the implementation and, you know, implementation is always in the details. And from a state, the premium assistance has always been extremely complicated with all the wraps and all the differences, and we've heard a little bit about that. And so while I think it's a very good option, we have to deal with the tension between CHIP rules and employer-sponsored coverage and exchange coverage. We talked about exchange and CHIP are very close, but even if they're a little different, that puts a lot of strain on states on how to do that. And the same goes with employer-sponsored, which then can lead to nothing happening. And so as we go forward, just that I'd

caution we think that through.

CHAIR ROSENBAUM: And do you think that that necessarily -- just as a follow-up that that would suggest not offering the option or offering options and letting states sort of find their --

COMMISSIONER DOUGLAS: Well, and I might get, you know -- but it might mean reducing, you know, if a state or if a family wants to stick with their employer-sponsored, then the CHIP rules don't apply, that that coverage is good enough and we're not going to -- you know, so -- and I'm sure we'll from the -- but things that do not just suddenly make it so complicated --

CHAIR ROSENBAUM: Right.

COMMISSIONER DOUGLAS: -- that option, that choice isn't there.

CHAIR ROSENBAUM: Right, for the family.

COMMISSIONER DOUGLAS: Yeah.

CHAIR ROSENBAUM: Okay.

COMMISSIONER MILLIGAN: Thank you. I'll be brief, and I want to sort of frame it a little bit differently.

I don't know that -- we've heard that the

Commissioners are not likely to support number 1, but I think from an analytic enterprise, we need to keep that data current in terms of the coverage effects of CHIP just went away. So I just want to be very explicit about that.

I guess I'm going to pick up on something Alan said just in terms of history. Part of the history of CHIP is that states had very different starting points when CHIP came up, and those different starting points persist to this day. And so I do think that it's worthwhile and I completely support an analytic enterprise, whether we just do 3 and sort of embed the regular CHIP program in 3, or do 2, also. I think that's worthwhile because it does reflect flexibility, it does reflect the history of the creation of CHIP. But because the starting points are very different for states and the coverage percent of poverty and the designs, therefore, have a lot of state variability, I do think we're going to come to a point in a future meeting where it's going to get to what Andy said earlier: How much are we really supporting more of a national model that really is more of an ACA framework that a child is a child is a child regardless of what state they're in as opposed to continuing to perpetuate disparate starting points?

Having said that, I think we need to do 2 and 3, and I also think I would like to see us support 4. And I think 5 should come off the table, personally, because I don't think that there's going to be any appetite for a Medicaid expansion as we've seen with the ACA adult coverage. And I don't think it reflects the flexibility that led to CHIP coming into existence in the first place as an alternative to Medicaid expansion. And I don't think that the litigation that came out of the ACA and sort of a mandate on states to expend match in a Medicaid expansion may not be viable. So I think 5 personally should come off the table.

CHAIR ROSENBAUM: Sharon, I have you down for a second -- for another comment. We'll let Gustavo go and then Sharon. But one question which sort of has been coming up as I've been listening to you around the room, and I want to be sure that we're capturing it right. We're gravitating around 2, 3, 4, some combination thereof. Alan raised a specific issue that I don't hear comments on. It strikes me this is where 3 and 2 actually are very different ways of framing an issue, framing the issue, and that is duration. 2, you know, could be read as simply

funding CHIP for another couple years; whereas, 3, we're saying something a bit more expansive when we say 3. We're saying that we think we're settling into a world where states are going to be in the driver's seat sort of trying to navigate children through a very complex coverage landscape, depending on the state and depending on the market conditions of a state.

And so there's nothing in particular around 3 and sort of the dog legs off of 3 that would be driven by the 2019 rules -- the 2017, 2019 rules of CHIP. So we can come back to this, but I just want to have you all bear in mind that there is a time issue that's sort of tucked into the 2, 3 tension. One is quite, you know, routine, and one is maybe a longer reach.

COMMISSIONER CRUZ: Yes, thank you. I just want to go back to the criteria options and maybe differ a little bit with my friend Andy. If you're going to benchmark just pediatric dental benefits, it should be with the Medicaid program under EPSDT they are the most comprehensive benefits. Only states that have expanded in Medicaid to include CHIP have similar coverage. The rest are benchmarked, usually within a private plan. So where

CHIP really sort of is shortchanged, we are going to do the -- just as you said, just benefits, is with the coverage.

Now, where CHIP has been very successful has been in provider recruitment, and I did not see that in any of the criteria, and I think it's very important. The penetration of providers under CHIP in most of the states, specifically for dental, is much higher than Medicaid. So if you're going to shift children to either the exchange coverage that we still don't know how it's working, it's only 30 percent they're offering the embedded dental benefit, they're going to be shortchanged in terms of finding a provider to see them.

So I think that's something that we need to keep in mind.

CHAIR ROSENBAUM: Thank you.

COMMISSIONER CARTE: Just following up Chuck's point, you know, we're looking for a way forward on the future of CHIP, and I would expect that way forward to maintain that a child is a child is a child, and we're seeking to address the really vexing problems of affordability and coverage equivalence to the extent possible. And also we're operating under certain timelines

as far as when the allotments have to be reauthorized and when the MOE ends. But, you know, I would hope it's certainly my expectation that Option 2 is maintained and it's the default option until those problems are solved.

CHAIR ROSENBAUM: Thank you.

COMMISSIONER WEIL: Just for fun -- since I'm new, I get to have fun for a little while -- I wonder if there's an overlay on top of all of these options that I'm going to call -- I pulled up something I wrote long ago.

CHAIR ROSENBAUM: It’s going to kill Chris.

COMMISSIONER WEIL: Yeah, I know. Just humor me for a minute, that's all, and then you can ignore it. I wonder if we should be thinking of something like -- and we're going to talk about 1332 waivers later -- a 1332 universal coverage option for kids, getting at Toby's issue and this issue of complexity. I mean, one question I wonder is: Could we convince five states that have low-single-digit uninsurance rates for kids to blow up these programmatic boundaries and come up with a standardized way to assure a high-value -- a comprehensive set of benefits for every child in their state that has to deal with these issues of how much do you wrap around employer coverage?

But, you know, the other thing we've done since CHIP was enacted is, not completely, but we have significantly standardized commercial insurance -- significantly reduced the variability in it, I should say, would be a better way to say it, and a truly universal approach doesn't have to interact with as many systems as it would have years ago. And why not just sort of open the door to a limited number of states that want to be creative in having the number of uninsured kids in their state be zero, but then if they make that commitment, to not have to deal with some of these programmatic boundaries, and just layer that on top of any of these options?

CHAIR ROSENBAUM: But we could add piloting, encouraging pilots of more universal and unified approaches, absolutely.

COMMISSIONER GRAY: Thank you. I could support that as well because, otherwise, conceptually the notion of fewer children insured -- like Peter, us pediatricians I guess stick together. Any step that would result in fewer children being insured would not be an acceptable alternative from my perspective, as well as I would add that the notion of state flexibility versus a standard

benefit coverage solution has to be slanted in favor of adequate coverage for children, and that is a value for me that is more important than state flexibility, although I understand the importance of having things that states want to do and are important to the states. But, you know, we are very, very close as a country to insuring all of our children, and anything that causes that to fall backwards I think would be really, you know, inconsistent with the mission of MACPAC, and like Medicare, has resulted in dramatic improvement in the health status of our nation's seniors, Medicaid and CHIP have done the same for children, and we're just on the precipice, and I would worry that this is really a tipping point for us as a country and that we shouldn't miss the opportunity.

Option 3, I share Toby's concerns about the complexity of it. I like it, but it makes my head hurt just sort of thinking about implementing it as well as just the confusion that it creates for families. But if we could be convinced that it could be done well in a practical manner that is easy to do -- and I'm not quite sure I see that right now -- certainly I could be supportive of that as well.

And like Sharon, I wouldn't be ready to toss Option 2 out with the bath water, you know, unless we really had a compelling better alternative. Otherwise, even if it's not a long-term solution, it is a solution that covers kids.

CHAIR ROSENBAUM: Let me just suggest -- and then we'll finish up [off microphone] -- where I think we're sort of moving. At a minimum what we're saying is we want to maintain the status quo, meaning we want to extend CHIP -- okay? -- whether it's the two-year minimum or whether we come out at a different number. But we also seem to be saying as a group that we are drawn to the idea, if we can make it work -- and I would note that people should recall that we are going to have to grapple with the issue of offsets, okay? And we've got to sort of pin down where we want the staff to take us because we're going to have to begin to put flesh on the bone, think about the cost, think about the administrative feasibility, and think about offsets.

But where we're sort of moving as a group, it seems to me, is also thinking about CHIP in a broader policy way as a mechanism to enable states to strengthen,

maintain, improve coverage for children under the unique circumstances of their markets. And that kind of vision for CHIP is a state-based vision, so one of the big tradeoffs obviously is the universality, at least for a while more, but what it does do is enable states during quite a fluid time in our policy world of health coverage to at a minimum continue to do CHIP as we've known it, and in a broader sense try other things that, depending on the state and depending on the markets, could go all the way from strengthening coverage in a state-based exchange, if that's how states are running their programs, all the way to applying the funds toward a universal program along with certain waiver authority that would be part of the statute. And that kind of vision wouldn't necessarily have the two-year endpoint. That would be a vision that would be a recommendation for some long-term change -- maintaining CHIP and making long-term changes in the program.

So we seem to be sort of zeroing in on this minimum step and then a more expansive step that would combine 2, 3, and 4 to some degree.

So now Toby, Chuck, Andy, Marsha. Marsha, why don't you start us off?

VICE CHAIR GOLD: I wasn't here in January, so I'm just sort of puzzling through this because I'm not as big a CHIP expert as a lot of other people here. And I'm trying to figure out whether there's one additional criteria or thought that goes into figuring out how these would work, and like Toby, I'm just trying to wrap my head around how you'd implement it, or what it would look like.

But, it seemed like when we had discussions last year, part of our interest was in sort of cross-child equity. That is, a child of a certain income in -- let's say just in a given state so we don't necessarily get into the whole cross-state equity, which has its own issues, but within a given state, there could be, I think, some random features as to where they end up, with which of these programs. And, I don't know how this affects it and whether it would be affected differently by some of these options, and if in sort of protecting the children who are cared for by CHIP now, creating inequities for people who come into the program in other ways.

And, that may not be the case, because, as I said, I'm not the biggest expert on CHIP. But, I don't know how these funds -- and they're not enormous. The CHIP

bucket, I don't think, is super enormous --

CHAIR ROSENBAUM: [Off microphone.] --

considerable funding.

VICE CHAIR GOLD: Yeah. I don't know how far it stretches, and that's part of my question.

CHAIR ROSENBAUM: You may want to put more in.

VICE CHAIR GOLD: Yeah.

CHAIR ROSENBAUM: Okay. Toby.

COMMISSIONER DOUGLAS: So, I definitely think four needs to stay, and I question whether we should be kind of building four into three and thinking of it -- back to the point that Alan made about thinking about the long term of a state option to, you know, use CHIP as an enhanced exchange, but it's just a consistent approach, would then get to testing, okay, maybe eventually we get to that, to number four altogether. So, just somehow, and maybe that was implicit.

And then five, I am very hesitant, like Chuck, to look at that, as much as, you know, I have bias on Medicaid. I don't think it answers the -- you know, then it starts to both get at the issue of state flexibility as well as the idea that I think I thought I was agreeing with

Alan on about bringing family coverage together, that we're just going to be bifurcating it more if we do that, bringing Medicaid requirements for children higher even than parents are, so --

CHAIR ROSENBAUM: Chuck.

COMMISSIONER MILLIGAN: So, Sara, I just want -- I was, I think, mainly responding to your summation. I think of four differently, I think, than maybe it was just articulated. To me, I think of four as having a more consistent national affordability for children up to some percent of poverty, 200 or 250, whereby the family glitch or pediatric dental embedded in exchange benefit design or exchange cost sharing reductions or all of that -- in other words, I can see a scenario that we should evaluate, and I will sort of hold to a later date kind of based on the analysis what I think is appropriate.

But, I can see a scenario whereby CHIP goes away and you don't have some states that are covering kids up to 400 percent of poverty in CHIP and other states covering kids up to 180 percent of poverty in CHIP, where whether you win or lose the lottery just depends on your address, and having some offsets that we do need to take into

account, but having some federal expenditure component that has more of a national equity for children to address the problems with exchange affordability or exchange benefit design, but whereby we're reflecting the more recent history of coverage expansions with national MAGI, national exchange, national CSR, national APTCs, and not perpetuating, as I said in my first set of comments, the world circa the BBA in 1996 or 1997.

So, I think of four as very distinct, very distinct from a state flexibility CHIP as a quasi-allocation to use how a state sees fit model.

CHAIR ROSENBAUM: So, in fact, what you have just laid out is the very reason why two years ago we only advocated for two years of CHIP funding, because at that point, the consensus was that a crucial priority was the repair of the family glitch and the better actuarial value for benefits sold in the exchange.

And, so, what I hear you saying is that you actually still think that that may be the better recommendation, with CHIP again remaining as long as it takes to do these repairs.

COMMISSIONER MILLIGAN: I think we need to

continue the analysis of that option, and then when we're ready to make a recommendation, know what that analysis shows.

CHAIR ROSENBAUM: Penny and then Andy.

COMMISSIONER THOMPSON: So, that was exactly one of the comments that I was going to make, which is that at the beginning of this conversation, I thought I understood the options, and then I started to think I didn't really understand the options.

But, so, that was exactly one of the points, which I thought the difference between three and four was under three, a state could decide to effectively augment its exchange coverage in a way that would produce greater coverage and benefits and more affordability for kids, and in option four, basically, that's how exchanges work, is that they have those features and elements.

So, I do think that it's actually helpful to distinguish more between the options. It felt to me like in our conversation we were smooshing them a little bit, and I think for clarity and contrast, it can be more beneficial to actually make them look a little bit more different so that it's clearer what the puts and takes are

between them and where different decisions produce different kinds of results.

The other point that I got a little bit confused about is this timing question. So, are we saying by definition option two is a two-year option, because that's also something I think we should take off the table. I --

CHAIR ROSENBAUM: Yeah. No, I mean, that's why I raised it, because I'm not sure what any of us was thinking, except that Alan flagged the fact that we need to think duration, not just --

COMMISSIONER THOMPSON: Yes. I mean, I agree that, you know, there's a duration element here just in terms of even trying to do the cost estimates associated with that and so forth. But, I certainly don't think that we should be trying to think about short-term program actions pending more -- first of all, I don't think two years is enough time to do anything. Both -- I mean, I think we're struggling -- I mean, obviously, I know why the Commission came to that decision earlier about its recommendation, but it's just hard to do a lot of good analysis and then do a lot of good planning and then create the kind of support and then have kind of the legislative

details and negotiations and then have an implementation -- like, all of that stuff just takes a lot more time than a couple of years. So, I wouldn't want to see us repeat that activity here.

CHAIR ROSENBAUM: Andy.

COMMISSIONER COHEN: What I was going to say when I raised my hand is a little different than where it ended up after these very helpful comments.

I think I kind of wanted to address your comment, Toby. I think when I think about option three, I think about CHIP in sort of a conceptual way, as a pot of money with some federal standards and some state flexibility, and it being applicable to a bunch of different markets. And whether or not the CHIP premium assistance rules exactly as they are today and the exact rules would have to perfectly match around what the exchange, I mean, I think, to me, those are sort of design considerations that could be significantly, you know, sort of considered and addressed, and so it's not sort of inherent that you're taking today's exact CHIP rules and sort of trying to plug it into a plug that doesn't fit very easily. You could adjust those things, because we're designing a policy recommendation.

But, sort of related to that, I wanted to maybe sort of tease out and unpack now what I sort of understand are some of the differences among two, three, and four a little bit more. So, you could have a -- one question is sort of where decisions lay for sort of whether or not you are wrapping around the exchange, employer-sponsored insurance, whether or not you can use your Medicaid program more or less, or you could use CHIP money in your Medicaid program or something like that. Should there be one sort of federal program and standard for all children, or should there be some federal standards, but some flexibility, sort of implementation by states so the states are kind of actually doing it, which is sort of how I think of three, or do you stick with two, where CHIP is CHIP. There's a lot of things that states can do, especially with waivers, they can do even more.

So, one question is just sort of how much do you have federal standards that go to, you know, sort of levels of income and coverage and other things, and I think you can have some level of that in three and you'd have a lot more standardization in four and you wouldn't have very much except for what we have today in two.

But, again, I sort of think of many of these things sort of on a continuum. So, one is the sort of standardization across income and coverage. Another is sort of who actually executes and design which markets are the right ones for CHIP to interact with? Who designs the benefit packages in specificity, and things like that.

So, I sort of see two, three, and four as a continuum and you could sort of have variations, really, among them quite a bit. But, the issues really go to federal versus state decisions, federal versus state implementation, et cetera.

CHAIR ROSENBAUM: Well, let me try saying it short, which is -- which is, we could say, at a minimum, everybody -- we deal with four, okay, which is what we said two years ago. I mean, this is what we were saying, okay. And then, though, instead of stopping as we did two years ago, to say do CHIP long enough to get to four, we could say, we want you to do four, but we also want to continue CHIP because we see a lot more going on than just four. We see strengthening benefit packages. We see trying a more universal approach. We see this sort of broader set of state flexibility measures to deal with local market

conditions.

But, at a minimum, what you can't have anymore is the family glitch and a low actuarial value for children. That has to be fixed nationally, and I think that's how we might approach two, three, and four, and have you go back and start to work them through. We're not making any final decisions today. We're just narrowing the field. It sounds like we're taking one and five off the table and we're sort of, you know, moving the blocks around in two, three, and four, which is great. I mean, we come out of here, I think, with a sense of where we want to go for the next couple of months so that we can work up and be back to a more solid view of the options, what we think these options might cost, what the options would accomplish if they're nested inside one another, and then, of course, this issue of offsets.

I do want to give the public a chance. I think it would be very valuable to us to hear from you now for a few minutes as we go off and ponder our next steps.

Any public comment? Oh, yes. Good. Thank you, guys.

PUBLIC COMMENT

* MS. ALKER: Hi. I'm Joan Alker with Georgetown University Center for Children and Families, and, you know, just absorbing. A lot to say, and I think you've raised some really important questions.

I think the children's community as a whole is really moving towards -- which I think is a very good thing -- about thinking about whole family coverage, and that's very important.

But, I do want to express a lot of concern and caution and really support some of the comments, both not only about not moving backwards on uninsuring kids, because we are making such incredible progress, and it is an area, I think, of brightness in our political discourse, which is somewhat dismal and dark.

But, also, I think it's important to recognize that we don't want to move backwards on the comprehensiveness and the value of that coverage for kids and the fact that they're getting strong coverage in Medicaid and CHIP.

And, that leads me to my next point, which is I think there's a real tension between, you know, in the considerations of building another platform, of premium

assistance, which, as you know, I've done a lot of work on, I'm very, very skeptical about whether wrap-around coverage works. I did recently author a paper with some colleagues at the Kaiser Commission on Medicaid specifically looking at wrap coverage. I don't really have time right now to go into that, but I would love if there's an opportunity in the future to come back and to present to you all some of those findings, because I think it would be helpful as you think about this issue going forward.

And then, finally, on the issue of simplicity, I think it speaks to both the complexity of getting the wrap done, but that in itself is a complex question, because sometimes I think there is an oversimplification of speaking on the concern of families, saying that families want simplicity. They absolutely do. They need simplicity in the enrollment process.

But, in terms of simplicity of coverage source, again, Kaiser did a series of focus groups with families who are on CHIP and they talked to them, and I attended some of them, to ask them what is most important to them about their coverage. And, it's not all being in the same plan. It's, number one, affordability, and I think that's

true of any family in our health care system, not just in CHIP. And it's the comprehensiveness of the coverage. And, they very much value their public coverage because it is affordable and because it is comprehensive, not that it doesn't have problems, but those are two fundamental concerns for families. And, I think, clearly, at least in that research, those trumped any concern about all being in the same program.

So -- and then I do think, while I'm very sympathetic to Andy's comments that we want to be mindful of simplicity for families, but less so for administrators, I work a lot in the world of Medicaid expansion waivers, and talk about complexity. In some of the places we've gone to, as a result of the political pressures around Medicaid expansion, these very complex deals have been reached, and they're, frankly, not really workable, I think, in practice. So, you see consumer protections being put in with the best of intentions, but they're not really viable. I don't think they're going to be viable at the end of the day. And, so, that's another one of the tensions that I think you have to grapple with.

So, like I said, I don't want to take up too much

time. I would love to come back and testify about some of the paper findings, because I think that would be helpful, and to think more about these issues. But thank you.

CHAIR ROSENBAUM: Yeah. Joan, can you send Anne a note, maybe, with links to the papers that you especially want to draw our attention to?

MS. ALKER: Sure.

CHAIR ROSENBAUM: Great.

Any other comments?

[No response.]

CHAIR ROSENBAUM: All right. We are going to take a brief -- do we have a break?

EXECUTIVE DIRECTOR SCHWARTZ: Yeah.

CHAIR ROSENBAUM: Yeah. We have a brief break, and then we will be back for more.

* [Recess.]

CHAIR ROSENBAUM: All right. Back to business, everybody.

So, Martha, take us away.

BRIEFING ON 1332 AND 1115 WAIVERS

* MS. HEBERLEIN: I will be with you for the remainder of the afternoon, so enjoy. So I'm going to

start by talking a little bit about Section 1332, which Alan brought up in the last session. So Section 1332 of the ACA established a new waiver authority for states, and there has been a fair amount of discussion of these and this new authority to alter state approaches to health reform. And there's also been a fair amount of confusion, especially in regards to how it interacts with Medicaid.

So there was new guidance released in December, and implementation is upon us. They can start as of January 1st, 2017. So we thought it would be a good time to bring the issue to you and have a bit of a discussion about the constraints and the opportunities associated with these new waivers.

So, Commissioners, I just want to point that there is in the back of the memo in Tab 6 -- there is a side-by-side that compares Section 1115 and 1332 waivers that hopefully is helpful to you.

So beginning on or after January 1st, 2017, the Secretaries of HHS and Treasury may waive provisions of the statute that deal with exchanges, qualified health plans, premium tax credits and cost-sharing subsidies as well as the individual and employer mandates.

I want to point out that Section 1332s do not apply to any Medicaid provisions, although states may wish to coordinate changes across Medicaid, and CMS is required to help facilitate some of that coordination, especially in terms of the application process.

Also, I want to note that while I'll discuss as little bit on state activities related to these waivers, no state has yet been approved for one.

So under the statute, Section 1332 waivers must meet certain requirements that are often referred to as guardrails. These were described in more detail in the guidance released in December, and specifically, coverage under these waivers must be comparable, affordable, and comprehensive, as would have been under the ACA.

So, in terms of comparable, a comparable number of residents must have minimum essential coverage under the waiver than without it, and that's regardless is coverage source. So, as long as the same number of people overall are covered, if that shifts, it would be deemed acceptable.

Coverage under the waiver must also be as affordable for residents as it would have been in its absence, and this is based upon a comparison of residents'

net out-of-pocket health care spending compared to their incomes.

Health care coverage provided under the waiver must also be as comprehensive as it would have been without the waiver, and this factor is assessed by the extent to which coverage meets the essential health benefits requirements.

Finally, Section 1332 waivers must be federal deficit-neutral over both the life of the waiver and a 10-year budget window.

So an important point in the December guidance also pointed out that this calculation will not include any savings that are accrued in a Section 1115 waiver, either a current waiver or a proposed waiver, so there's no cross-subsidization.

So although a larger number of states have expressed interest in 1332 waivers, only a few states have publicly released applications, and only one so far has submitted an application. What has been released so far have been fairly modest in scope and are really more designed to keep the status quo within the state as is operating now.

So Vermont was the first state to release an application and did it on the 15th, just a couple weeks ago, and they are looking to waive some of the Small Business Health Options Program (SHOP) requirements due to technical difficulties during implementation of reform. Their SHOP marketplace wasn't working, and employer and employees enrolled directly through insurance carriers. And the state wishes to continue that arrangement as opposed to having a SHOP website.

Massachusetts and Hawaii have both released -- publicly released applications, and Massachusetts has a merged market that it's had since its own health reform efforts, and that has both individual and small group coverage. And while merged markets are allowed within the ACA, there's a couple features that are unique to Massachusetts that the state wishes to maintain.

Finally, Hawaii also has a longstanding health reform from the mid '70s called the Prepaid Health Care Act, which has higher standards than are under the ACA for employer responsibility, and again, they want to keep those standards going forward as opposed to moving into the ACA.

So looking at a comparison to Section 1115

waivers, as you recall, a Section 1115 provides broad authority to the Secretary of HHS to approve demonstrations that are likely to assist in promoting the objectives of the Medicaid and CHIP program, and Section 1115 waivers have been used in a number of ways over the years, including to expand eligibility, require managed care enrollment, restructure hospital or safety net financing, benefits and cost sharing, and there's some more examples in the memo in your book.

These waivers are required to be budget-neutral, meaning that federal spending under the waiver cannot exceed what it would have been in the absence of the waiver. This is different than the 1332 requirement, which is deficit neutrality, which also includes changes in federal revenues.

There is a public process in transparency requirements at both the state and the federal level for Section 1115 waivers. Rob reviewed those in December when we commented on the transparency report, and for example, state must have a 30-day public comment period prior to submitting a proposal to CMS. And the Section 1332 waivers are subject to very similar public review and comment

process.

As research and demonstration waiver, Section 1115 waivers are subject to periodic reporting and evaluation of the state by the state and may also be subject to federal evaluations.

While Section 1332 waivers are subject to ongoing reporting and cooperation with outside evaluations, there is no state evaluation component in the Section 1332 waiver.

So looking at the interaction between Medicaid and Section 1332 waivers, I said this before, but I'm going to say it again. Section 1332 waiver authority cannot be used to waive any provisions with Medicaid. However, because of the potential for overlap and the continuum of coverage, CMS is required to coordinate Section 1115 and Section 1332 waiver requests, and depending upon what the state is seeking to waive, this may involve coordination across a number of agencies, as shown in the slide.

In addition, an assessment of 1332 waivers will take into account any effects on Medicaid, but that's while holding those Medicaid policies constant. So, for example, any change in Medicaid enrollment as a result of the

changes proposed in a 1332 waiver would be considered as they're assessing whether or not to approve it.

So the guidance is clear that these sort of spillover effects will be taken into account when considering the approval of 1332s, but they haven't offered a whole lot of detail about what policy changes they will approve and how those changes may interact with Medicaid going forward.

So some of the challenges associated with these new waivers, as discussed previously, states cannot combine savings under Section 1115 and 1332 waivers into a single budget/deficit neutrality test. So, as I said, that means that savings for Medicaid cannot be used to offset spending in the exchange or vice versa.

The December guidance also put forth some more operational-type limitations. At this time, the federal exchange and the IRS are unable to accommodate different rules for different states, which makes some proposals not possible at this time.

For example, the guidance specifies that waivers changing the premium tax credit calculation, open enrollment period, or plan management reviews are not

currently feasible in states that rely on the FFM, or the federally facilitated exchange. As such, it may be more likely for states operating their own exchanges to pursue Section 1332 waivers.

Furthermore, given the timing of their implementation, January 2017, there is going to be a change in the administration at the federal level, and that may alter some of the parameters under which states can seek these waivers. So states may hold off to see what the new administration might have to say.

So, as new proposals come out, we will continue to monitor them and look to see what states are proposing in Section 1332 waivers, what impact it might have on the Medicaid program, and continue to keep you posted.

So I look forward to any discussion you may have.

CHAIR ROSENBAUM: Questions? Discussion?

[No response.]

CHAIR ROSENBAUM: I have one. Can you give us a sense of what especially the state reaction to the policy guidance put out to date has been? Where are the states in thinking about what CMS has laid out as an approach?

MS. HEBERLEIN: I think that states saw the

guidance as limiting their opportunities to use 1332s. I think especially in regards to the budget implications and not being able to use savings from one program into another program, I think that has limited the appetite for some states to take things up.

COMMISSIONER THOMPSON: Can I ask a follow-up to that, Martha? Do we have a clear sense about what some states might have been anticipating wanting to do that would have involved a kind of cross-waiver budget-neutrality approach? Were they intending to drive savings through Medicaid activities that would be used to supplement more coverage on the exchange side? Were they intending to use stored savings that they had accumulated over the years in 1115 for that purpose?

MS. HEBERLEIN: I'm not sure exactly how states were looking at the budget neutrality. I know that Arkansas, for example, in their 1115 waiver, they currently use exchange credits, and they were trying to look at how they might align things more across exchange and Medicaid. So whether that meant -- one of the options they were talking about was making the Medicaid package look like exchange credits or what you would get in a QHP, so things

like NEMT or other Medicaid-specific benefits would not be there, which is not really a -- may not be a budget issue.

COMMISSIONER THOMPSON: Right.

MS. HEBERLEIN: I know that Minnesota at one point was thinking about aligning the definitions of household and income between the two programs, which again I don't know how much of a deficit budget-neutrality issue that might be. I think they were more thinking like as you go forward up the continuum that if you're using the same definitions, that might make it easier for families and easier for administration purposes.

COMMISSIONER THOMPSON: Right. Because I've heard that same kind of feedback that it came out that people were disappointed. It was pretty restrictive. Cross-program savings have always been an ongoing issue about how you calculate budget neutrality, but I was also trying to really understand the practical implications and whether or not it was a matter of potential puts and takes on exchange versus exchange side in terms of costs that were kind of an accidental artifact of something that you were trying to achieve for really policy an operational purposes versus kind of an explicit desire to take money

out of the Medicaid side to give it to the exchange side, which is what I think the guidance is trying to prevent.

CHAIR ROSENBAUM: Yeah. I mean, I've often wondered as well. Given the existence of the basic health program option that is just a smoothing mechanism for lower income people that works in tandem with Medicaid, how much the cross-fertilization that might have been made possible by a 1332, but it turns out not to be there, whether that ended up being a big deal, or states that were thinking about cross-fertilization would have gone down the basic health program route anyway, and very few have done so. So the limited response to basic health program made me wonder, other than these very specific uses, like Vermont or Massachusetts or Hawaii, whether we're ever going to see this big flowering around 1332.

Yes, Toby.

COMMISSIONER THOMPSON: I was just going to say I think in the case of basic health, it was operating in the opposite direction, which it was helping states with costs that they were otherwise absorbing and getting more federal -- so it was working to their advantage in those particular circumstances in those particular states that took it up.

COMMISSIONER DOUGLAS: I mean, my take on some of these states that were looking at combining the two, to be honest, gets to our discussion this morning on flexibilities. I think they thought that it was a way of getting around Medicaid rules that exist and a way to use kind of 1332 as a way, but given not just the financing, but the 1115 -- the Medicaid rules aren't changing under this. So it couldn't do that.

I am still trying to get my hand around what 1332 then will do. Is it mainly around employer-sponsored? Is that what states are looking at of having to use more -- to expand employer-sponsored?

MS. HEBERLEIN: I don't think they are looking at it to expand employer coverage. I think there could be tweaks to exchange policies; for example, what QHPs or exchange plans you let in, what's the plan management focus. I think there might be other increased subsidies, although that would only have to happen -- that would be more difficult, given this guidance, and that the IRS wouldn't be able to do something on a state-by-state basis.

So I think that the talk I've seen has been more on the exchange side of things, and whether that's the

market changing the open enrollment period, like what QHPs are in and then further subsidizing them, that sort of -- I have not heard a whole lot on the employer side of things.

CHAIR ROSENBAUM: Explicitly excluded, of course, is any waiver of ERISA shield. So to the extent that states might have tried to move toward -- I mean, it was put in there to allow a state to try a single-payer system, was really the origin of it, and of course, when it became obvious that ERISA imposes constraints, although they're not total -- I mean, you could construct a state health reform initiative that steers clear of ERISA limits, but the deeper issue was the kind of taxation increases that you would need, even though you were going to have offsets in other ways.

But there is nothing that allows you to take head on self-insured, employer-sponsored plans. They have remained protected. So you have to do workarounds for that, and I think that's a limiting factor.

I've been quite struck by the fact that when you get right down to it, 1332 is extremely limited, and I have been struck by all of the articles that have come pouring out about this great alternative way, when that is actually

not why 1332 was put into the law.

Well, thank you. So now you can put on your other hat.

REDUCTIONS IN ADULT ELIGIBILITY POST-ACA

* MS. HEBERLEIN: All right. So, to end the day, we'll talk a little bit about reductions in adult eligibility since the ACA, and I want to -- just a few caveats before I get started is that this look only looks at full benefit Medicaid enrollees, so it doesn't take into account changes in eligibility under waivers, more limited coverage like family planning services.

Also, at this point, we're not able to provide any concrete numbers, so I apologize ahead of time, of how many people may have been affected by these changes, although we are still exploring some data options, especially as they relate to churning in the future.

So, to begin, we are looking at these changes as part of a larger body of work to look at the impact of the ACA on Medicaid. This has been raised at the Commission at the last retreat and other times to sort of know what's happening in Medicaid as a result of the ACA, and so this includes, for example, the ongoing tracking of state

expansion decisions, including an issue brief that compares the six states that have used waivers to expand as well as chapter last March that looked at the premium assistance waivers in Arkansas and Iowa.

We also have a relatively new section on the MACPAC website that looks at the ACA, and this provides an overview of said sections of the law as well as the impact on enrollment, spending, and coverage that's based on our work and the work of others, and we'll continue to update that as things come out.

And, we are looking at this particular issue because there were concerns when the ACA passed that once the new coverage options were available under the ACA, so the expanded Medicaid and the exchange subsidies, that states would roll back existing Medicaid, and that's why the maintenance of effort was put in place to hold coverage until these new options became available.

So, taking a step back, under the ACA, states must maintain eligibility enrollment policies in place from the date of enactment until implementation. So, specifically -- Chris talked about this a little bit before -- the MOE was in effect for adults until January 1, 2014,

when the exchanges were fully operational, but remains in effect for children through fiscal year 2019. And, as I mentioned, the goal of the MOE was really to maintain existing coverage until the new ACA options were available to states.

So, today, I'm going to take a quick look at some of the states that have reductions in eligibility since the MOE expired.

So, we're going to start with parents and caretakers. As of December 2009, 17 states covered parents at or above 100 percent of the FPL. Of these, ten covered parents above 133. These 17 states are listed on the slide on the table and, as well as in the memo in your binder.

So, nine of these states covering parents above 133 rolled back eligibility, and you can identify those states by the second column from the right that shows the date, and that's when they rolled back eligibility. And, you can see where they started in 2009 versus where they are today, in January 2016.

So, of those states, you can see Maine and Wisconsin are non-expansion states and they reduced eligibility to 100 percent of the FPL.

Among the expansion states with pre-ACA levels above 133, you have Connecticut and the District of Columbia, which have maintained higher eligibility thresholds. Connecticut rolled back in 2015, but still maintains a higher threshold than 138. Then you have two other states, Minnesota and New York, that have adopted the basic health plan up to 200 percent.

And Rhode Island and Vermont that provide additional subsidies to exchange enrollee individuals. And for those of you who were here in December, Joanne walked through how those additional subsidies work. Basically, they provide state subsidies to supplement the federal subsidies to lower the cost of exchange coverage for families, or adults.

So, five of the states with parent eligibility thresholds between 100 and 133 have increased eligibility as they expanded coverage to the new adult group under the ACA. And Tennessee has not expanded to the new adult group, but has maintained its pre-ACA eligibility threshold.

CHAIR ROSENBAUM: Can I just stop you for one second --

MS. HEBERLEIN: Yes, ma'am.

CHAIR ROSENBAUM: -- because I want to come back to this and note, you are saying that a couple of states here, in fact, do a supplementation. They buy up the subsidy some more.

MS. HEBERLEIN: Yes.

CHAIR ROSENBAUM: They end up with a more generous subsidy, which, of course, relates back to the previous discussion we were just having about how -- what apparently in the children's world we call wrap-around. Here, we're just calling it a buying up of the subsidies. And, I think it would be worth coming back to this, because this issue continues to sort of plague us, and yet we see a couple of states that are actually doing it.

COMMISSIONER GORTON: And Massachusetts has done it [inaudible].

CHAIR ROSENBAUM: Yes.

MS. HEBERLEIN: Mm-hmm. So, looking at adults without dependent children, prior to the ACA, only a handful of states provided full Medicaid benefits to this group. As of January 2011, there was only seven states, and all of these states have since adopted the Medicaid

expansion. In two of these states, again, the District of Columbia, has maintained that coverage at higher levels above 133, while Vermont, when they rolled back for parents, also rolled back for childless adults, but, as I said, provides those additional subsidies in the exchange.

Looking at pregnant women, three states have made changes to pregnant women since the expiration of the MOE. Oklahoma and Louisiana reduced eligibility in their Medicaid programs, but maintained their unborn child coverage in CHIP, and so the overall eligibility threshold has not been reduced. Virginia eliminated its CHIP program for pregnant women, but has since restored it. So, in these three states, there have been changes, but, effectively, the coverage eligibility threshold remains the same.

CHAIR ROSENBAUM: Do we know why Virginia did one thing, then the other? Did it become obvious that they could not enter the exchange in the special enrollment period and --

MS. HEBERLEIN: You know, I'm actually not sure why Virginia reinstated. It didn't last very long, I know. I think it was less than a year where their coverage was

not there, but I'm actually not positive as to why.

Finally, looking at the medically needy, five states have eliminated medically needed spend-down coverage since the MOE expired. Hawaii and North Dakota eliminated it for non-elderly, non-disabled adults. Illinois eliminated it for parents. And Indiana eliminated the coverage for aged, blind, and disabled when it converted how it conducted its disability determinations for Medicaid. Pennsylvania eliminated it, but similar to Virginia has since reinstated it. When they did their expansion, they eliminated the coverage, and then the next year, they brought it back. But, again, I can look into why they've brought it back.

So, I think, overall, the message is that prior to implementation, it was really unclear if states would reduce eligibility thresholds in response to the new coverage options available to individuals. But a look at this eligibility changes since 2014 shows that, overall, states have made very few changes, and where they have, they haven't really created gaps in coverage.

So, I'll use Wisconsin as an example. They rolled back their parent eligibility to 100 percent, but

those over 100 percent would be eligible for subsidies on the exchange. So, while we don't know for sure whether those people in Medicaid have been moved to exchange subsidies, we do know that there was a coverage option available to them.

But, as state decisions are dynamic and with the enhanced funding expiring next year for the new eligibility group and 19 states not taking up the expansion, states will continue to make changes to eligibility going forward and we'll be sure to keep an eye on this.

But, for now, we thought that understanding what states have done in light of the new ACA coverage options may hold lessons for the MOE for children when that expires, as well as how future changes to the program may affect states' decisions about eligibility.

CHAIR ROSENBAUM: I think it's worth noting that there are sort of two issues at play here. One is obviously the actual income standard that you set for people in the Medicaid program, which you may end up as a state keeping more generous because Medicaid is a different benefit structure, different cost sharing structure, particularly for people with heavier needs.

But, the other issue which I assume plays into states' thinking, at least to some degree -- my guess would be that it showed up with the pregnant women, although New York now has legislation to blunt this -- is that Medicaid has no specified enrollment period. So, you can enroll when you need the coverage. And, if you should have employer coverage, of course, or Medicare coverage, you can have Medicaid and a third party coverage. And for, of course, for parents with children with disabilities, this is a huge, huge issue. A lot of children enrolled in Medicaid because of their special needs may have a parent working with employer coverage.

So, I think this is something that's really worth watching, and I think as you point out, when the state expenditure requirements start to go up -- Chuck and I were talking before about the financial issues, the economic downturn that's going on in some states, but also as the financial obligations of states start to climb in the expansion states, we may see more efforts to offset costs for the expansion population by trimming the rolls of the optional population.

So, any comments? Andy, what has been the effect

-- I don't know if -- I mean, this is unfair, you didn't know I was going to ask you this, but what's been the effect of creating a special enrollment period in the New York exchange for pregnant women? This is quite an issue now.

COMMISSIONER COHEN: I'm not going to be able to tell you very much. People are very proud of it, think it's absolutely the right thing to do for maternal coverage, but I don't know if there's been, like, any sort of evaluation or data that's gone out there --

CHAIR ROSENBAUM: On what the effect is --

COMMISSIONER COHEN: Yeah.

CHAIR ROSENBAUM: Well -- oh, Chuck.

COMMISSIONER MILLIGAN: So, just again, an anecdote, really, from my background in Maryland. Sometimes there might be changes, like pregnant women coverage, in the future that really aren't necessarily related to the MOE or necessarily related to the ACA. I will give one specific example that seemed to be coming up more and more. The anecdotes were becoming data as I was leaving Maryland.

As more and more employer-sponsored insurance

moves in the direction of high deductible type plans or HSA type plans, there are a lot of women who have employer-sponsored insurance, become pregnant, Medicaid will pick up the coverage, and Medicaid ends up paying first dollar because the provider doesn't want to try to collect the high deductible that the employer-sponsored insurance has underneath and it's easier simply to bill Medicaid.

And, so, I think that one of the dynamics that will underlie some of these eligibility decisions that states make is not simply MOE or ACA stuff, but ways in which employer-sponsored insurance benefit design changes and HSA models impact Medicaid increasingly maybe becoming more primary and less secondary in certain other ways. So, I just -- I want to be careful, if we do start to see trends, that we don't create the wrong causal connection.

CHAIR ROSENBAUM: Well, and that the interesting thing is -- we were just talking -- that when you see writing on value-based insurance design, which often talks about exempting from the deductible primary care and medications for maintenance conditions, you really never see maternity as part of a high-value design. So, that means that your maternity benefits would be subject to a

deductible, and yes, that, I'm sure, would drive Medicaid --

VICE CHAIR GOLD: Even prenatal --

CHAIR ROSENBAUM: They talk about primary care and maintenance drugs, but not -- you don't really see maternity care explicitly.

COMMISSIONER MILLIGAN: We were -- as I was leaving the Maryland Medicaid job in the spring of 2014, we were seeing a lot more instances where, from a coordination of benefits perspective, the work wasn't happening sufficiently, and it was really women who had employer-sponsored insurance, but it was high deductible and Medicaid was paying first.

CHAIR ROSENBAUM: Any other comments?

[No response.]

CHAIR ROSENBAUM: We have time once again for public comment. Do we have any public comments? Thank you, Martha.

PUBLIC COMMENT

* MS. WIEAND: Hi. Betsy Wieand from the American Congress of Obstetricians and Gynecologists. Thank you for that great discussion.

I just would like to highlight that in Louisiana and Oklahoma, because the women who have been moved into CHIP are covered under the unborn option, they don't get postpartum care or any family planning postpartum because the fetus is the one that is covered. So, while it appears that the eligibility is intact, in fact, there is a lessening of coverage that I think is masked by the comments which were made by staff, which were very insightful and helpful, but I just wanted to highlight that issue.

Thank you.

CHAIR ROSENBAUM: Thank you.

MS. WHITENER: Hi. Kelly Whitener from Georgetown CCF, and I actually wanted to go back to the earlier discussion, but first, a quick point.

I think it was the change in Governor in Virginia that led to them reinstating their pregnant women coverage.

[Off microphone conversation.]

MS. WHITENER: Also, from my previous hat.

But, returning to the CHIP discussion, one of the things that was kind of floated around among the Commissioners was perhaps rejecting option number five of

increasing Medicaid eligibility, and I understand a lot of the political dynamics around that option. But, I think it would be important to, at the very least, consider whether states could have the option to increasing Medicaid eligibility, which is not something that's totally clear today, whether they could increase child eligibility in Medicaid or in CHIP.

CHAIR ROSENBAUM: [Off microphone.] Aha, because of the changes that were included in what CHIPRA -- on limiting the --

MS. WHITENER: Because of CHIPRA limitations on the delta between Medicaid and CHIP.

CHAIR ROSENBAUM: Yeah, yeah.

MS. WHITENER: And then Medicaid limitations on the removal of the R-2 income disregards.

CHAIR ROSENBAUM: Yes. Exactly.

MS. WHITENER: And that effect to MAGI and how that all trickles around. So, it's not totally clear today. I think, at the very least, it probably could be done through a waiver, but something that you'd want to consider --

CHAIR ROSENBAUM: Sure.

MS. WHITENER: -- as a potential additional option for state flexibility.

CHAIR ROSENBAUM: Thank you for raising that.

MS. WHITENER: Sure.

CHAIR ROSENBAUM: Any other comments?

[No response.]

CHAIR ROSENBAUM: If not, we are adjourned until tomorrow morning. Thank you. Commissioners, of course, you are staying put.

* [Whereupon, at 4:07 p.m., the proceedings were adjourned, to reconvene at 10:00 a.m. on Friday, April 1, 2016.]

PUBLIC MEETING

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

Friday, April 1, 2016
9:59 a.m.

COMMISSIONERS PRESENT:

SARA ROSENBAUM, JD, Chair
MARSHA GOLD, ScD, Vice Chair
BRIAN BURWELL
SHARON L. CARTE, MHS
ANDREA COHEN, JD
GUSTAVO CRUZ, DMD, MPH
TOBY DOUGLAS, MPP, MPH
HERMAN GRAY, MD, MBA
LEANNA GEORGE
CHRISTOPHER GORTON, MD, MHSA
STACEY LAMPKIN, FSA, MAAA, MPA
NORMA MARTÍNEZ ROGERS, PhD, RN, FAAN
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
PETER SZILAGYI, MD, MPH
PENNY THOMPSON, MPA
ALAN WEIL, JD, MPP

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:59 a.m.]

CHAIR ROSENBAUM: All right. Why don't we assemble ourselves. Good morning, everybody. Happy Friday. It's a little hot and steamy outside. We're getting ready for summer in Washington, D.C., for those of you from elsewhere.

We're going to start right away. I know that 12 o'clock comes quickly and a couple of our Commissioners, I think, may have to leave a little bit early, so we want to be sure and get through this morning's session on long-term care.

We are very fortunate to have Stuart Butler and Katherine Hayes with us to start us off. Stuart, of course, is with the Brookings Institution. Katherine is with the Bipartisan Policy Center. And they have a joint project examining financing and delivery of long-term care. We are extremely grateful that you gave up your Friday morning to come in and talk with us. And they don't have slides. They're going to present for a little bit. There is a handout. And then we will open it up for general discussion.

PANEL: RECENT PROPOSALS ADDRESSING THE FINANCING AND DELIVERY OF LONG-TERM CARE

* MR. BUTLER: Okay. Well, thank you very much, and it's a great pleasure to be here and to talk on this particular subject.

As you mentioned, Sara, there's a lot of overlap in a lot of the efforts going on in this area. I was an advisor to the BPC project. There were BPC people involved in this collaborative project that I was involved in, as well. There's LeadingAge that's been looking at these areas. And, it's interesting that so much of the conclusions of each of these is very similar. There's a lot of overlap, as you'll hear, between us.

It's also important to understand that, certainly with regard to BPC and the collaborative, we sort of approached the issue in different ways and yet came to a very similar conclusion. I'll leave Kathy to say a little bit more about the BPC process.

The collaborative process brought together various stakeholders, people with very specific interests in this area, and used the process of facilitation and mediation to try to see where the areas of agreement were.

So, it wasn't a research issue -- approach, or anything like that.

The organizations included think tanks like Brookings, the Heritage Foundation, Center on Budget Priorities, a wide range of perspectives. Various organizations were involved, like the Jewish Federation, Families USA, National Coalition on Health Care, and others. We had also former state and federal officials there and various industry-related groups, like America's Health Insurance Plans, various nursing home organizations, Milliman and Associates, that played a very important role in the design of the mechanism to look at different alternatives.

And, just let me give you just a very quick overview of kind of all the recommendations of the collaborative and then focus more specifically on the Medicaid area.

Probably the most -- the recommendation that has got the greatest reaction and interest was the call for a universal public catastrophic program for LTSS, partly to deal with the tail-end risk of private insurers and the concern that many insurers are dropping out of the market,

in part because of the uncertainty associated with that part of the risk section.

And, also, the findings of the Urban Milliman modeling on this area, which all the organizations used, really showed very clearly that a voluntary catastrophic plan was really not viable. So, that moved a lot of people, including myself, I have to admit, towards a universal catastrophic program.

There were also very significant impacts for Medicaid, actually, from that recommendation, because the largest gainer, in a sense, of a federal universal catastrophic program is really the Medicaid program. So, that had a lot of implications which we can talk about a little bit later on.

Secondly, there were a number of steps to improve the take-up rate of private insurance. Part of the idea was to strengthen the private insurance part of the challenge. So, for example, having long-term care insurance as an opt-out provision in an automatic enrollment employer-based system was recommended, as was the more standardization of benefits to make it easier for people to understand what they're actually getting.

And, then, we also recommended exploring combining long-term care insurance with other forms of insurance, such as life insurance, Medicare, and private insurance, without a lot of details, I confess.

The third recommendation, which I won't go into in any great length, was to put much greater focus on families and communities as service providers, caregivers, and to deal with the issues of training and support and various other aspects.

But, the fourth area, and I'll just spend a few more minutes on this, was the notion of looking at the Medicaid program in different ways with regard to long-term supports and services. And, basically, we had three aims in that part of the recommendations from the collaborative.

One was to essentially separate Medicaid's long-term supports and services from the acute care portions of Medicaid. Many people would continue, and most people who currently have LTSS would continue to have that, of course, through Medicaid. But, the idea of taking that part of Medicaid that dealt with specifically long-term supports and services and make that a somewhat separate area that people could enroll in separate from the acute care part of

Medicaid. And, I'll say a little bit about that in just a second.

Secondly, simplifying the eligibility and the coverage availability of these services through Medicaid.

And then, thirdly, to give much more ability for states to manage an experiment with variations of services within that area. So, each of these -- these were three parts, and we looked at this as essentially modernizing the Medicaid program to deal more effectively with long-term supports and services, and to make that part of it more available to other parts of the population.

So, in terms of separating LTSS Medicaid from the rest of Medicaid, the proposals would expand eligibility for a higher level of income than currently is available for Medicaid services generally and eliminate -- and in so doing, attempted to eliminate this gap, this huge gap between people who can look forward or be on Medicaid for these major services and those who can afford current insurance and have -- and are adequately prepared to sort of deal with that middle section, who are kind of falling through the cracks at the moment, to give them an opportunity to join a form of Medicaid with income-related

premiums associated with it. So, enabling people to buy into Medicaid long-term supports and services.

In terms of eligibility and coverage, the proposals would reduce some of the distinctions and some of the eligibility requirements right now, making institutional and non-institutional eligibility essentially the same, so service could be provided in either way, either through an institution or not through an institution, to really eradicate the distinction between mandatory and non-mandatory services, and to make it easier for people who have LTSS under Medicaid in terms of its expanded section to do so with making it easier for them to continue working and to build assets at the same time.

In terms of state flexibility, we certainly strongly supported the idea of moving much further towards giving greater authority for states to combine medical services and traditional LTSS services with housing services and support and other social supports, to move very much in that direction to begin to start to break down the silos in terms of budgets and availability of services so that states can start experimenting with much better mixes of enabling people to age at home and so forth, and

also encouraging much greater use of home and community-based services generally.

Let me just end by just saying a little bit about the effect of the impact of the universal catastrophic insurance protection with regard to Medicaid, because there would be a gain, a kind of windfall gain, so to speak, to both the states and to the federal government. We had a lot of discussion about that. We did have state officials who reluctantly, in some cases, I think, agreed to some of the expansions of services through Medicaid LTSS in their states and were worried about the costs of that. But, also, the fact that this catastrophic protection would also reduce their potential liabilities factored into that conversation.

And, we came to the conclusion that to the extent that there would be a net savings to any state of the combination -- after the combination of expanded services, but also this universal insurance program, then the states would be required to have a maintenance of effort -- they would have a maintenance of effort requirement particularly focused on the sort of front-end benefits of improving the basic services at the earliest level of becoming eligible.

So, that's how the equation kind of fitted together. Like all negotiated documents, it gets a little fuzzy here and there and there are a number of things that were not specified in detail, such as the financing of the universal public catastrophic. We looked at various things, and you'll see if you look at the document itself, we presented a menu of options, but there was no full agreement on any of them.

But, there was -- I think the Medicaid part of it was carefully negotiated. It was intensely negotiated. And there was very broad support for the final recommendations.

Thank you.

* MS. HAYES: Thank you very much for inviting me to be here to talk about the Bipartisan Policy Center's initial recommendations on long-term care financing.

First, I'd like to say a little bit about the Bipartisan Policy Center. It was established in 2007 by former Senate Majority Leaders Mitchell, Baker, Daschle, and Dole. Our long-term care initiative was started two years ago, and the four leaders that are involved in that project are former Senate Majority Leaders Bill Frist, Tom

Daschle, former Governor and Secretary Tommy Thompson, and former CBO Director Alice Rivlin.

As a part of this project, we knew going in that we would have certain limitations. When we first began working on this, it was right after the Affordable Care Act had been passed. We had seen the controversy around the class act, the repeal of the CLASS Act, watched the Long-Term Care Commission and saw its deliberations.

And our leaders gave us a few instructions going into this, and they said, first of all, they'd like to see a proposal that is politically viable. They would like to put something out there that policymakers could take a look at and it could be seen as first steps and it wouldn't be completely overwhelming.

The second piece is that they wanted the proposal to be fiscally sustainable.

And, third, in terms of political viability, they had a couple of issues. Again, following the controversy around the Affordable Care Act, they wanted us to stay away from individual requirements to purchase long-term care insurance. They wanted us to stay away from state mandates in the Medicaid program. And, again, they wanted to make

sure that it was fiscally sustainable.

So, in addition to this initial long-term care financing proposal, this is the first in a series of reports on long-term care and the integration of clinical and social services and supports. Our first report, which I will talk about in just a little bit of detail, came out February of 2016. We are looking at improving the long-term care delivery system. That will be coming out in September of 2016. We will have a phase two of long-term care financing, which will come out in March of 2017. And, finally, we are looking at the needs of individuals with multiple chronic conditions and those who need long-term services and supports that are partial benefit dual eligibles and also the Medicare-only population, and that report will be coming out in May of 2017. So, we really have our work cut out for us and we'll be focusing on this issue.

Today, I'd like to provide a quick overview of our 2016, February 2016 report, phase one, and then go into a little bit of detail about the Medicaid provisions and talk about next steps.

The recommendations around long-term services and

supports framework, they would like to make private long-term care insurance more affordable and available by offering retirement private long-term care insurance; streamlining the Medicaid home and community-based state option and waiver process to encourage more states to adopt an HCBS state option; offering a lower-cost Medicaid buy-in for working individuals with disabilities that would be designed to wrap around a private long-term care insurance policy for those who are receiving employer-sponsored care or receiving coverage through the state marketplaces, state and federal marketplaces; and they also very briefly acknowledged that there is a point in which risk for care is so high that there is no role for the private market in that area. This is for catastrophic long-term costs.

The four of them agreed that this is really an area in which the federal government needed to step in, that families were saving for retirement, were depleting those retirement savings, savings that they need to live on for decades, and that because private long-term care insurance has not been viable over the long term, those policies are now providing coverage for only two to four years. And for those that have catastrophic out-of-pocket

costs or catastrophic care costs, there should be a federal public program. They did not go into any level of detail as to how that would be structured or paid for, and that will be considered as part of our next steps over the next year.

So, in looking at the Medicaid program in particular, they hope to streamline and consolidate plans, the existing options. There are about four state options under the Medicaid program that allow states to move forward and provide home and community-based services. Our process, unlike the convergence process, is really a research-based product, outreach to stakeholders, getting feedback from stakeholders, and then negotiation by our four leaders in coming up with policy recommendations. And, I'll be glad to go into the details on the home and community-based services, state plan option, and provide information that we gained in our outreach to stakeholders.

And, again, permit states to offer an LTSS only Medicaid buy-in program, and there would be -- one of the key components of this is that a state could decide through an individualized assessment what services an individual would need. And, so, an individual could purchase personal

care services on a limited basis, and that premium would be based on a sliding scale.

The benefit would begin for individuals who have incomes over 250 percent of the federal poverty level and there would be no cap on income, knowing that because it's an income-related premium, at some point, it would be more cost effective for an individual to pay out-of-pocket than it would be to pay premiums.

So, with that, I will end, and thank you very much.

CHAIR ROSENBAUM: Thank you. Can we open it up to questions? Comments?

I have one to start. Katherine, I wonder if you could talk about sort of -- you and I have had this discussion many times. There are so many distinct authorities in Medicaid for long-term services and supports, and they have proliferated over the years for many reasons, and they work in different ways, and they deal with specific subpopulations. And so if you could talk a little bit more about what your thinking was underlying in terms of how agency decisionmaking should happen; in other words, which things did you all decide

really should be an issue for states to determine as a state plan, discretionary matter, using their normal flexibility to design their programs, and which issues still in your view, if any, still should require some additional CMS oversight beyond normal, you know, state plan requirements.

MS. HAYES: Thank you. We did really look at all of the options. There are a number of them. There's 1915(c), the home and community-based waiver program, which you're familiar with; 1915(i), which is the home and community-based option, and actually I want to say, first of all, that everything I know about Medicaid I pretty much learned from Sara over the years, and she helped us develop the 1915(i) waiver when I was on the Hill; 1915(j), which is self-directed services; and 1915(k) included as part of the Affordable Care Act, the community choice option.

What we tried to do is really take the best of all of those options. One key piece of this is the leaders felt very strongly that we needed to allow states to set income and eligibility levels for these services. I think the things that we need to consider going forward if we do come up with a streamlined option is the waiver of

statewide-ness and comparability and thinking about how states -- how to encourage states to move forward in a way that allows them to have some certainty as to what their expenditures are going to be, but at the same time, offer a meaningful benefit.

In allowing individuals to -- in allowing the states to set eligibility levels, the one sort of sticking point that we really had was 1915(c), the waiver program, which allows the states to cap the number of individuals that are eligible for services versus other state options, which if the state picks it up, there is an entitlement nature to that program.

Ultimately, in our streamlined recommendation what we did was took the approach in 1915(i) which allows states to estimate the number of individuals that would be eligible for services, and once they reach that cap stop enrolling individuals. So it still maintains the entitlement status of the program, at the same time gives states some predictability.

One of the issues that came up as we were talking to states about why they weren't using the state option is that there was a lot of misunderstanding about these

programs and what they could actually do within these programs. So we were hoping to highlight and consolidate to make it easier for states.

Sorry if that was a little long-winded.

COMMISSIONER DOUGLAS: Thank you. As you went forward with your proposal and recommendations, how did the dramatic movement of states towards managed long-term care fit into this? And when you think about state plans and the 1915(i) and all the different options, once you move under managed long-term care, it's a very different equation. And so states moving in that direction, that's part one of my question.

And then part two is whether -- when you start thinking about expanding Medicaid long-term services and supports to higher incomes, it still has the same question of the intersection with Medicare and impacts on states of expanding a benefit that has interactions and benefits to, you know, another program of not addressing this continual problem of the silos of the two programs from a state perspective is, you know, an issue.

MS. HAYES: Yes, we are considering that issue as part of our long-term delivery reform. It wasn't included

in our initial financing recommendations. That report will be out in September of this year. One thing that we've been looking at in particular is trying to eliminate the barriers to the integration of services in the Medicare and Medicaid program, and funding, at the same time funding. We're looking at all programs that serve dual eligibles under current law, including the duals' special needs plans, the PACE program, the Medicare/Medicaid plans through the Financial Alignment Initiative. And looking at those programs, we are identifying those areas that we see as barriers to the integration of those programs and making policy recommendations.

At the same time, our leaders ask us, you know, does it make sense to go through each of those programs? Or should we think of building a structure from the ground up that takes into account the needs and the financing of both the Medicare and Medicaid programs and allowing integration of those services?

MR. BUTLER: I should add that we had a very similar kind of conversation among the collaborative group. There was a subgroup focusing very specifically on Medicaid, which I was not part of, so I don't know all the

discussions there. But it certainly goes very much along the same lines, that the general presumption was that we should move forward, first of all, towards a much more managed system generally at the state level with regard to the medical services and health-related services and to absolutely see that and to look at the maximum opportunity, so ending these distinctions between institution, non-institutional and so forth as an example of that. So there was really a very broad consensus about that.

There was also a broad consensus in principle about trying to find ways to really integrate much more effectively LTSS and Medicaid in that regard, and other health services such as Medicare and also private coverage in various ways. So we had a lot of discussion, for example, about whether you could or should blend a long-term-care and supports insurance into Medicare Advantage plans and also into employer-based coverage, you know, during that period.

I have to say I think there was a lot of pushback on some of the technical feasibility of some of these. There was not a lot of agreement about exactly how you could do this, either in Medicare Advantage or with private

insurance, and so the recommendation was more to explore that area and to really go in that direction. I don't think in principle there was, that I can recall, any deep-seated opposition to that, more a question of whether it be feasible or not. And there was a lot of difference of opinion in regard to that.

MS. HAYES: If I might add one more thing, in looking at the report that will be coming out in September and thinking about how one might develop a new structure of a fully integrated program, we recognize that that was the intent of the Medicare/Medicaid plans through the Financial Alignment Initiative in the Centers for Medicare & Medicaid Innovation.

But one of the concerns that we learned about coming from the plans and the states was that even though this program was really meant to be aligned in practice, it isn't. And we've really been trying to dig down and figure out what the problems are. Some of it we see as a problem with the structure of the requirements in CMMI to begin with, and the question of whether or not it's really realistic to expect these plans to be able to achieve savings of 1 percent in year one, 2 percent in year two,

and 3 percent to 4 percent in year three, particularly given that the way the capitation rates are set for both Medicare and Medicaid. Medicaid in particular, there is a concern that there's a lot of unmet need out there for individuals who have been enrolled but not receiving services.

So one of our proposals -- we expect this will be one of our proposals that comes out in September -- is to find a way to move a fully integrated program outside the requirements for CMMI. If you need to have a budget neutrality requirement, perhaps you shouldn't expect anything until year six. So you would be able to give plans the funds to invest in the first year, in the first few years, and also make up for some of the unmet need there.

Another issue that we're thinking about is if we are looking not just at fully capitated Medicare Advantage special needs plans, most of whom are participating in these programs, but if we're going to structure something that would work for other types of plans such as accountable care organizations, patient-centered medical homes, is there a way to come up with some sort of budget

or capitation? And if one could do that, why couldn't you just say, provided that you got the appropriate quality measures, consumer protections, and physical integrity provisions in there -- and that is going to be difficult, I must say up front. But if a plan or provider group is living within a budget, why do we really care what services are covered under the Medicare and Medicaid program? Why wouldn't we let a provider group do an individualized assessment of someone and determine what they need and provide those services, regardless of what is covered under either state plan?

By taking -- and this is something that we're really struggling with because there is concern about the ability of some of these plans to offer services on a capitated basis to this very high needs population. But if one could put the appropriate structures in place, it would give plans and providers much more flexibility to cover things that are not covered by either program right now and to allow them to integrate with community services. You know, when you look at the federal budget right now, we increasingly see a reduction in appropriated programs and an inability of -- you know, we would like to integrate a

lot of these community services as well, for example, you know, allow these plans to provide meals if they need to, allow them to go in and provide for home modifications, for pest and rodent abatement, for asthma, you know, an air conditioner for individuals with asthma, but really look at the needs of an individual and see what we can do to help. You know, when we think about it, we say, you know, maintain or improve health and functional status.

MR. BUTLER: I would just emphasize that last point that Katherine made in terms of looking at the range of services and allowing need to be the basis rather than eligibility for a particular background or history. It absolutely was an emphasis in the collaborative as well. I think that's an area where there was complete overlap even those BPC went into more detail on that and explored it a lot more. But there was absolute support for that, and I think that kind of fits in general into this notion of going to kind of a managed system where you're looking at basic need and allowing as many programs and services to be integrated into this, whether it be air conditioners or housing issues and so on. That was absolutely central to the support and the consensus with the collaborative group.

COMMISSIONER MILLIGAN: I have been waiting for you, Brian, to come into all of this.

[Laughter.]

COMMISSIONER MILLIGAN: So I work at -- a long background in a lot of this stuff, but I now work at a health plan that, in fact, does deliver managed long-term services and supports, does have a D-SNP also. And so I just -- a little bit of context and then a couple of questions.

So we're doing home modifications, air conditioners, utility payments, pest abatements. It's wonderful work. I'm in New Mexico, and when the river -- the mine spill happened and it flowed into the Navajo Nation, we had folks out there keeping people at home with delivering bottled water for people who were living on wells and, you know, all of that stuff. It's difficult from a payment point of view because for rate-setting purposes it's hard to figure the encounter-ability of it. So that is a contextual thing I do want to raise. And it's also difficult from an integrated Medicare/Medicaid point of view if what you're avoiding is the hospital visit but you're paying on the Medicaid side, you know, how does that

-- how do you even do cross-programmatic substitution? So I just want to offer you that context first.

So two questions. The first is maybe the easier question, which is: To get to Toby's point, why wouldn't the proposal either -- wherever it's emanating from -- be more around somebody buying a wraparound to Medicare to offer LTSS and leaving Medicaid out of the picture for higher-income individuals? Because it's not simply the integration of Medicare and Medicaid that's the complexity. It's substitution. It's who's primary, who's secondary about things like is personal care going to substitute for home health nurses. I mean, it's all of those kinds of things. Why not simply have it as a Medigap version or a buy-in version to Medicare? And why is Medicaid the vehicle for this for higher-income people?

MS. HAYES: It doesn't have to be the vehicle for this. In fact, in Phase 2 of our long-term financing piece, we're really looking at higher-income individuals as well. Two of the options that we are exploring is a limited LTSS benefit that could be offered through the Medigap market and also through Medicare Advantage. We assume at this point that it would be financed, and we're

trying to find the right balance between a meaningful service and keeping premiums for beneficiaries as low as possible.

In working with -- we've been working with the state of Minnesota on their project, which is very similar, and looking at the initial data that we have seen from Milliman, it would have to be something that was -- you know, because of risk selection issues, it would have to be a mandatory service in all Medicare Advantage programs, and it would also have to be a mandatory service in all of the Medigap programs.

So we're looking at the costs there. We'll be doing additional scoring with Milliman, looking at the cost based on what private long-term-care insurers are offering. At the same time we'll be using Acumen to price out the services on the Medicaid side to develop the appropriate benefit package.

MR. BUTLER: Among the stakeholder groups that were involved in the collaborative conversation, there was a lot of discussion about what was the best -- the term we used, the "best chassis" to build on. Should it be Medicaid? Should it be Medicare? Should it be something

else, something new? And there were a lot of factors involved in that, including practicalities that I mentioned already.

I think another, which was really important, was thinking about the potential impact on long-term federal finances, and I think there was a lot of concern -- there was a lot of concern expressed in using the Medicare chassis to do this, largely for sort of political reasons, I mean political in the sense of how one thinks about the political dynamics of Medicare, and whether there was enough capability in addition for Medicare to experiment at the margin in quite the way -- a more state-based Medicaid approach. I think in general the feeling was that in an area like this, experimentation -- and trial and error experimentation, because there are going to be errors -- is best done at the state level and, therefore, within Medicaid would be the better chassis for that purposes. But because other kinds of services were involved such as housing and all the things that you mentioned, again, better to have a chassis that's based more at the state level. So there were multiple reasons I think why.

Now, that said, as I think I mentioned earlier,

there was interest in exploring whether an LTSS insurance component could be grafted on to the Medicare Advantage program. I think there was certainly a lot of openness to say let's do that under the current levels of financing and so on and see what happens rather than say let's require it or let's kind of expand Medicare Advantage with this in mind. I don't think enough of the people around the table were willing to go -- you know, to commit to that area.

So I think, you know, it was all of these factors, as you would expect in a group of stakeholders like that, including former federal officials who worry about deficits and think tanks who worry about deficits, too, sometimes.

COMMISSIONER MILLIGAN: So I had one more question. I'm sorry. And it's really, I think, the crux of it. So I'm going to just be really candid. I'm a skeptic because of adverse selection, and I think that a lot of the challenge of the CLASS Act, a lot of the challenge with earlier demos like the partnership models where, if people brought private long-term-care insurance they could retain more resources and qualify for Medicaid,

all those kinds of versions, I think that the financing part, Stuart, that you're alluding to, if it's a voluntary program for the individual, if it's not -- and if it's -- I don't know how you surmount adverse selection. And so I'm curious about your thoughts about that.

MR. BUTLER: Well, we had several people in the collaborative who said almost exactly what you just said, almost exactly the same words. And I would just sort of say a couple things.

First of all, we both mentioned the role of Milliman and the Urban Institute in this. You know, a very important part of this whole conversation in all of it, LeadingAge as well as the two of our approaches, the availability and the improvement of the Urban Institute model to look at implications, and grafted onto that, of course, was the Milliman component looking at insurance systems and insurance pricing and so on.

There were a lot of limits to that model. It couldn't tell us lots of things, in part because of just its technical functions, but also in part because it costs money to do this, and there was a limit on the resources that could be put in. So whilst the issue of adverse

selection and some of the other aspects of potential costs you mentioned were absolutely discussed, I think -- well, I know there wasn't an ability to come to agreement about that because there were differences of opinion about what actually would happen in these situations. And that's why you'll see in our report that's kind of left -- that's one of the vague aspects of it, and to explore it.

But as I also said, I mean, the concern clearly about adverse selection was very high, and also the concern about what the potential cost would be and where that cost would lie was of great concern. But we didn't have an ability, at least in the collaborative, to really resolve that sufficiently for there to be any kind of consensus agreement. That's why you'll see various funding mechanisms discussed sort of in principle. Some people favored one, some the other. But there just wasn't an ability to come together either from a research perspective or from a preference perspective as to how to resolve that. I think we both agree that, you know, these reports that have come out now are a step, and a very important step, to the next stages of refinement, to looking more thoroughly at some of these things, maybe expanding use of the Urban

Institute Milliman model down the road to start to explore the degree of adverse selection that's -- there was a lot of disagreement about that. Some of the insurers at the table were disagreeing with each other about what would happen.

CHAIR ROSENBAUM: Brian.

MS. HAYES: And I --

MR. BUTLER: Sorry.

MS. HAYES: I was going to say -- and I don't think our leaders oppose a universal program. There was just a feeling that until the dust of the individual requirement of the Affordable Care Act sort of settles, they didn't want to put something out there that would immediately be rejected by current policy.

MR. BUTLER: The term "universal" is important as opposed to "mandatory."

MS. HAYES: Yes.

CHAIR ROSENBAUM: Brian.

COMMISSIONER BURWELL: There is so much I could say. I guess I would start out with an observation, which is there have been a number of these types of long-term care financing reform initiatives in recent years. I do

see some movement towards increased consensus around a voluntary insurance program is not viable, and so greater support on both sides of the aisle that there has to be some type of public insurance option, with the idea being that if the public insurance program can reduce the risk, the overall risk to the consumer, a private market might be able to fill in the balance. But the way it currently is, it is uninsurable. You know, it's just private long-term care insurance market is going down the tubes. There's no doubt about that. So that seems to be a direction where a lot of these deliberations are going.

Of course, then the next question is, how much of a mandatory program are we willing to support? What's it going to cost? Nobody wants to use the word "taxes," but we're talking taxes, and that should be put out on the table because it's going to cost. And we do have a good model now. The Urban Institute model is extremely good. We can price this thing out. So I am encouraging everybody, put prices on things and put it out there, so there's no further debate.

Next, I want to encourage these types of efforts to address the hard issues, and around integrated

Medicaid/Medicare models, there are several very difficult issues that I think require greater visibility. One has to do with whether enrollment is voluntary or mandatory. We all probably know that one of the issues in the current demonstration is that there are very high opt-out rates on the Medicare side, so that even though people passively enrolled, a lot of them are choosing to disenroll very quickly.

There are a number of reasons for that, and a lot of states would like to be able -- I would say states are enthusiastic about managing the duals population, but they very much think that mandatory enrollment on the Medicare side is a necessary prerequisite for that.

The other issue that Chuck alluded to is, who takes the risk and who takes the savings? Currently, it's very much Medicare takes its savings and Medicaid takes its savings, but there are cross-program effects. We all know that. So some type of bold proposal around how risks and benefits are distributed in an integrated model would be a contribution to the discussion.

MS. HAYES: And that is exactly what we're looking at in our September 2016 report. We do not have

the leaders' approval of this, but one of the options on the table is allowing combining of a Medicare and Medicaid rate and allow any savings to be used, any savings on the Medicare side be used to provide additional services, so that once you received this capitated rate, there would be no expectation in the first five years that any of the savings would accrue to the federal government. It could all be used at the state plan.

COMMISSIONER BURWELL: You have to remember there are three parties. There's Medicaid, Medicare --

MS. HAYES: Medicare.

COMMISSIONER BURWELL: -- and there's the plans.

MS. HAYES: Plans, right.

COMMISSIONER BURWELL: So it's a three-party agreement.

MS. HAYES: Yeah. And, in fact, in terms of the structure of this new program, it's hard to go up to the Hill right now and say, "We think there should be a new regulatory structure," because people just sort of shake their heads and say, "We're not doing any new programs."

So what we've been thinking about is using the three-way contract model as a basis for this new regulatory

structure and figuring out a way to bring both Medicare, Medicaid, and plan experts to the table to talk through what the key provisions -- what are the key provisions that need to be in this three-way contract.

As you know, they took the Medicare Advantage contract and sort of grafted on Medicaid benefits, and in many states, it's just not working that well, particularly when you think about the grievance and appeals processes and a number of other issues. So we are really hoping that the leaders will agree to come up with this recommendation for a new three-way contract.

COMMISSIONER BURWELL: Even if you don't think it's politically viable over the short term, I highly recommend that at least, you know, it be put out there because these things are important and need to be addressed.

MS. HAYES: I think it could be politically viable, so long as plans, states, and providers are willing to work within some sort of budget or capitation. I think there would be a lot more comfort there, at least from our members.

MR. BUTLER: Let me comment on both your points

quickly. One, you're absolutely correct. I think one of the things we absolutely have seen is a recognition that a voluntary catastrophic system really is not viable, and I think around the collaborative at least, there were these sort of periods of confessions going on with people who had adhered to that idea, including myself. And we had sort of counseling for those people to help them make this step forward.

[Laughter.]

MR. BUTLER: That said, I think there was a pretty vigorous conversation about, well, what do we mean by a public program that a mandatory program in the sense of saying if we mean by a mandate, you, an individual, are required to do something, sign up or pay something, as under, of course, the Affordable Care Act, in order to get benefits, that at the moment would be a very hard thing to sell. And it doesn't have to be the model.

One can have a universal system, which is available to everybody, who meets certain conditions, without a specific requirement that they must even sign up, but certainly that they must make some contribution through their life in some way.

I mean, most programs that people have available to them are not mandatory in the sense of they have to sign an agreement in some way and make a contribution. So there was a lot more interest in looking at financing mechanisms that were not of the kind of the Affordable Care Act mandate, but for political reasons, but also for technical reasons because -- or at least for long-term political reasons, I think there's a lot of worry about the idea of, say, a payroll-based, payroll tax-based public insurance program for fear that it may end up with a disconnect over time between the cost of the benefits and the political acceptance of raising tax rates so that they were in line. We would get a rerun of the unfunded obligations of the Medicare program. There was a lot of resistance, therefore, to that form of mechanism. I'm much more interested in other forms of taxes that might pay for this.

Let me just say very quickly that, as you said, one of the implications of the public insurance element is this impact on Medicaid, is this savings from Medicaid in principle by substituting this federal program.

There was a lot of robust conversation about whether the net savings to Medicaid and to the states

should form the basis of itself a maintenance-of-effort requirement on the states, the pushback being that the other provisions that had been supported by members of the collaborative to expand availability of the LTSS up the income level and to adding other services would eat away at any gains that a state might make. That's why we ended up with this recommendation, sort of awkward recommendation, to say, "Well, let's see what the impact to the public program is in your state, compared with the extra services you're providing and so on. If there is a net gain to you, then yes. Then you are required to spend it on front-end services," but in many cases, there would not be a net gain, was the argument. So that's why we had this kind of messy provision in the recommendations.

CHAIR ROSENBAUM: So we have time, I think, for two more questions. We've got Marsha and Toby.

VICE CHAIR GOLD: I just want to pick up briefly on what Chuck and Brian were raising because I had occasion to look at the financial alignment demonstration and the dual eligibles, both when I was at Mathematica talking to Jim Verdier and also looking at it for Kaiser Family Foundation a while back.

I encourage you to do what Brian said and really look at what some of the real messier issues are. Particularly, I was interested in your talking about the rates and the issue. From a managed care perspective, the plan, you're right. I mean, the plan wants to get a total rate, and technically should have some flexibility within that subject to whatever protections beneficiaries need to use the money, whatever makes sense.

I think what happens, though, is that you have funds that are tied to the Medicare program, and you have funds that are tied to the Medicaid program, and it's these cross-substitutions. The state says Medicare is going to gain more, and it wants more. The Feds want more. It wasn't, I don't think -- and I would encourage -- I don't know, Brian, if your evaluation of the dual eligibles had some detailed process descriptions of how these things worked with the --

COMMISSIONER BURWELL: [Speaking off microphone]

VICE CHAIR GOLD: Oh. Well, whoever had the evaluation. I'm sorry. There is an evaluation. Oh, RTI had it, and Mathematica is doing the support for it. If there is any documentation as to some of the decision-

making and maybe talking to some of the people involved --I don't think it was done well. There are some real legal constraints, and just the reality of having program authority in two different places where you have funds flow back and forth is a real challenge. Would you agree?

COMMISSIONER BURWELL: I totally agree.

CHAIR ROSENBAUM: Mic, please.

COMMISSIONER BURWELL: I think it would be nice to get that information, but I think it will be very difficult to obtain.

VICE CHAIR GOLD: From my perspective, it would be very helpful to the extent you can really talk and say, "Here's what happened," and sort of try and embed that reality into how you go forward. I think it potentially could have been handled better, but I don't know how realistic certain solutions may or may not be.

MS. HAYES: Yes. In discussing this with folks in the administration who worked on this, my understanding is that one of the primary challenges were requirements within the Centers for Medicare and Medicaid Innovation and the structure of those and also sort of a bit of a tug-of-war with OMB as they were putting this together and needing

to demonstrate savings.

As we put our proposal together, we are hoping by requiring -- by allowing this, by allowing budget neutrality over a five-year period, with no expectation that the federal government would achieve savings, and by allowing true integration of services that plans would have the ability to spend on services, regardless of where they're coming from -- so we explicitly say you can spend trust fund dollars on this. When I've gone in and talked to folks in the administration, they tell us that the way they structure this program should allow complete flexibility. They should be able to spend Medicare dollars on things that are traditionally not Medicare-covered services, but when we've talked to plans participating in these demonstrations, they say this is not the case.

We keep hearing that it's because of reporting requirements in there, and we're really trying to dig into this and what the issue is. And as best I can discern now, it has something to do with reporting back, so they can determine what the shared savings should be.

So, if we get rid of sort of the shared savings piece at least for the first few years and figure out how

that would work, we are really hoping to achieve that.

CHAIR ROSENBAUM: Toby.

COMMISSIONER DOUGLAS: Yes. Just building on this, rates matter. I'd say that's definitely on the Duals Demo as an issue, but the biggest issue really gets back to what Chuck said and Brian said. It's really around the true integration, and the opt-out in all the states -- and California has made it very difficult to see how it's going to survive over the long term, and it really needs to be addressed as the true thorny issue. You have a mandatory enrollment on one side, and you have a voluntary on the other. It's the same population. We need to address the issue of are we going to have an integrated program and deal with long-term rebalancing. Then you need to have the acute, and it can't work with you have huge opt-out and voluntariness on one side. That will deal with the risk issue and the rates, and I think plans would be fine in participating even with savings under that model. That wasn't the issue in California.

MS. HAYES: Yeah. And I think our leaders in particular are a little sensitive to the lack of experience in plans, in providing services to dual eligibles. Some of

them are very good at it and have done it for a long time, but there is some concern that in sort of rushing into this new model and moving at the rate that they did and perhaps states wanting to opt into this for the purposes of savings rather than true integration of care -- and I'm not criticizing states. They have a lot of balls to juggle right now.

But I think what our leaders would probably say to that -- and, again, I don't know for sure. We haven't discussed this, but just based on discussions we've had in the past, it's until we have a little more data and experience to show that plans are able and providers are able to integrate Medicare and Medicaid services for this very high-risk, high-needs population, there is a little discomfort in requiring individuals to enroll without an opt-out.

COMMISSIONER BURWELL: I just wanted to add I think one of the other barriers is just a philosophical-in-mindset approach that I think the payers still kind of see integrated models from a health insurance perspective. It's really a population management initiative, and it should be approached from a policy point of view as

population management, not as health insurance.

CHAIR ROSENBAUM: Kit, you get the last question and last answer. We're just about at time.

COMMISSIONER GORTON: So just an observation, actually, because the last few sets of comments have talked about managing this population, and we've had lots of learnings in Massachusetts, and one of the most important learnings is this is not a unitary homogeneous population. And so one of the hardest things we've found -- and I think it applies to some of the things you both have said -- is that the under-65 duals are very, very different people from the over-65 duals, and that which works for over-65s does not necessarily work for the under-65s. The illness burden is different. The social determinants are different. The ability to find and engage with these people are different.

And I would make a plea to you, as you are looking at these, to deconstruct that population and start looking particularly at the needs of the under-65 duals as opposed to the over-65 duals.

I think, to your question, Katherine, the plans, particularly those with extensive experience in the senior

care world may in fact be ready to deal with the over-65 population. I think in Massachusetts, we've learned we're not ready to deal with the under-65s, and I worry that in places where the two have not been separated that the under-65s get masked by the experience of the over-65s.

CHAIR ROSENBAUM: Thank you very much.

We will go right into our last presentation on functional assessments.

All right. So, here is our last session of the morning, and Kristal, take it away. And, we assume that Brian will do -- will lead off our comments a bit and then we'll open it up.

REVIEW OF DRAFT CHAPTER FOR JUNE REPORT: FUNCTIONAL ASSESSMENT FOR MEDICAID LONG-TERM SERVICES AND SUPPORTS

* MS. VARDAMAN: Okay. Good morning, Commissioners. This morning, I am here to provide an overview of the draft report chapter on functional assessments and long-term services and supports, which we're preparing for inclusion in the Commission's June report to Congress.

The draft chapter, which was included in your

meeting materials, describes the current state of functional assessments and the results of MACPAC's research, which we presented some details on in the October 2015 meeting, as well as the meeting in January of this year. The report also discusses varying perspectives on a national assessment tool, which there was a good deal of discussion about at the last meeting in January, and the chapter does not include recommendations.

In terms of outline of the chapter, it begins with a discussion of eligibility pathways for LTSS and the role of assessments in eligibility determination and care planning.

It then describes the federal role in assessments, discussing federal guidance and regulations, as well as initiatives that have been put in place by CMS in order to incentivize functional assessments and their development.

It then discusses the results of MACPAC's research on state variation in functional assessment tools and our interviews with states on factors that influence their choices.

And, finally, it discusses various issues and

moving towards a national assessment tool and the advantages and disadvantages of such an approach.

The next few slides are really a recap of some of our prior discussion, so I'm going to go over them at a pretty high level. But, just as a reminder and refreshing, assessment tools are used both for eligibility determination as well as care planning in LTSS. And depending on the state, they can be conducted by a variety of entities, often some state or county employees, contracted vendors, et cetera. They are typically conducted face-to-face in a beneficiary's home in order to get really the full perspective on what some of their limitations may be.

When it comes to care planning tools, the tools may be the same used for eligibility determination or a separate tool. And to add some of the entities that are conducting assessments, in states with managed LTSS, the person conducting the care planning assessment may be the care coordinator that is employed by the managed care plan in which the beneficiary is enrolled.

So, starting in October and again with some additional results in January, we discussed the results of

some research that we had contracted on assessment tools and doing an environmental scan of the tools that are currently in use by states. And, our contractors found at least 124 distinct functional assessment tools currently in use, and I say distinct, or at least, because this does not include tools that may be used by managed care plans and states with MLTSS. States may mandate that a plan use a particular tool, in which case they may be included in that 124. But, in states that allow plans to use a tool of their choice, those tools are often proprietary and, thus, would not have been included in the review.

In most states, the tools that were being used for eligibility determination were also being used for care planning, and the contractor found wide variation in those tools, although they generally assess at a broad level functional limitations, clinical needs, but often solicited different levels of detail and specificity on individuals' needs.

In terms of our interviews with states on the choice of tools, we found that states develop home-grown tools when they feel there's no real clear advantage of an existing tool, and states were often motivated by feeling

like there was a need for customization of the tools that they were using, and also resource availability was an important factor, as states noted that it can take a great deal of time and resources in order to implement and develop a new tool. For example, some states may choose to use an independently developed or off-the-shelf tool rather than develop their own tool given that the time spanning developing that and testing that can be quite significant.

We also have described in the draft chapter some of the federal initiatives that have been related to functional assessments, starting with the Balancing Incentive Program, which did provide some funding that states could use to implement new tools. This was targeted to states that were below 50 percent in terms of their total LTSS expenditures that were spent on HCBS. And, as states that participated in that program could earn funds that then were used for various structural improvements in their LTSS delivery systems, including assessment tools where there were needs to develop new tools or make changes to their existing tools. The Balancing Incentive Program did require that certain domains be included in the tools of the state's choosing, but did not require the states to

use any particular tool.

We also discussed in the January meeting the Testing Experience and Functional Tools demonstration that is currently underway at CMS, and in this demonstration, among several other tools that they are testing, one is a test of assessment questions that they are piloting with a subset of the states participating in this wider demonstration. And, the goal is that these test questions, these test sections, will give states the chance to have a set of questions that have already been pretested and validated. So, states that are looking to develop new tools will already have something to build upon. And, as we noted in our interviews, we did find that states noted the resources involved in developing a new tool can be substantial, so this may help them move along more quickly.

The chapter ends with a discussion of the advantages and disadvantages of a national tool, trying to capture some of the comments that we heard in January. And, among the advantages, we discussed that having a national tool with those results collected and reported to the federal government would provide additional information that could be used for comparisons of utilization that

reflect similar levels of need, which could also help to improve our understanding of the value of different kinds of LTSS services that are being delivered to beneficiaries. And, finally, it would also reduce the state resources involved in developing new tools.

However, among the potential disadvantages, a national tool could, of course, pose a burden to states that have recently invested in the development of new tools at great expense and with a great deal of stakeholder involvement. Also, it could be difficult to select, as you all discussed in January. There's no clear nationally preferred tool, and there's so much change in this LTSS landscape that finding a tool that will meet the needs of every state as well as address the needs of really moving targets among the states as they continue to rebalance, as they continue to implement MLTSS and other initiatives could be a difficult task.

And, so, the chapter really concludes saying that despite the advantages that could come from a national tool, it would be a difficult time to do so currently, and, thus, the Commission would continue to monitor this issue, monitor the results of the TEFT demonstration and the tools

that they'll be testing and piloting in the states, and consider returning to this issue in the future.

CHAIR ROSENBAUM: Thank you.

MS. VARDAMAN: So, in terms of next steps, we'll plan to finalize the chapter and look forward to your comments. Thanks.

CHAIR ROSENBAUM: Sorry. Sorry about that.

So, Brian, and then Penny, and then let's open it up for discussion.

COMMISSIONER BURWELL: So, Kristal, I think you did a great job in making the changes. I really think the chapter is in very good shape for publication.

I think the chapter does a very good job of kind of conveying kind of the current state of art around this, which is pretty messy and a lot of change going on, and a lot of further change coming down the road, particularly with the continuing shift to MLTSS and who determines eligibility criteria for LTSS benefits, for one, which has impacts on rates paid to plans and also how care plans are developed within an MLTSS framework.

So, I think it provides an excellent foundation for kind of future work and, umm, you know, I don't know if

this is something that the Commission continues to want to explore, but there's certainly a lot of additional avenues that we could pursue if we wanted to continue along these lines.

I entirely support the decision not to make any recommendations at this point. I don't think we're at a sufficient place to make any kind of recommendations and I don't think the field is, either.

COMMISSIONER THOMPSON: I agree, and I think that you did an excellent job of responding to the conversation that we had at our last public meeting around whether or not we should move forward with a recommendation specifically with regard to national tools. So, I think the chapter does a very good job of reflecting that feedback and conversation.

I also agree with Brian, which is that I think that we ought to, as a Commission, think a little bit more broadly about the kind of ecosystem here, not just the tools that are being used, but the way in which people are evaluated for eligibility for long-term services and supports and the way in which care planning is done and by whom. I think that that is -- that opening up the aperture

into that kind of larger world, I think, will allow us to both put this work in better context, and then as additional data and evidence develops around what kinds of questions and what kinds of data are most useful, that we'll have a better way of understanding how those additional tools should fit within a larger environment of both government and sometimes county and plan resources and how they're deployed to look at and on an ongoing basis evaluate whether people are both eligible and what kind of services are going to produce the outcomes that people are looking for.

CHAIR ROSENBAUM: Sharon, and then Kit, and then Marsha.

COMMISSIONER CARTE: Well, while I appreciate the good work that is in this chapter, Kristal, I feel kind of uncomfortable if there's nothing more. I well appreciate that 124 tools is too many and one is too few. But, I would hope that there could be something more that we could do or point to, to push this issue along.

After having spent a couple of years just trying to understand the difference between the types of physician surveillance and assessment and what it takes to

developmentally assess a child, I think there's similar development work called for in this area, and I'd like to know to whom we turn to ask for that. I mean, the IOM, geriatricians?

Even the presentation that just preceded this, you know, I found myself thinking, as somebody who's had to care for an aging parent at home and try to manage the care for somebody with dementia at home, now in assisted living, and as I struggle to keep that person from going into a facility, it just seems like the question of functional assessment in a -- with more knowledge about what tools are appropriate when and can do what, is greatly needed.

I feel it's kind of a lack just to stop and say, well, you know, we found that there's 124 tools, but -- and we know that that's too many, but not to point to somebody and say that this has to be worked on.

CHAIR ROSENBAUM: I have to say that I sort of share a -- I share your, I think, somewhat confusion here, knowing that there are so many kinds of disabilities and so many combinations of disabilities and so many different service needs. And, yet, I think it's hard for those of us who are not steeped in this issue to quite understand where

does the variation happen? What are the underlying drivers of this variation? Aren't there certain enduring functions that we must know about in people with disabilities? And aren't there certain sort of enduring services, like, you know, if you have a physical disability, there should not be a place where you don't have falls prevention mitigation efforts going on.

I mean, it just -- it strikes me -- I guess I share some of Sharon's confusion, even after having read the very good chapter and knowing how dense this area is. And, so, anything we can do to illuminate why -- why this degree of uncertainty about how to move forward, and at what point do we think we have enough knowledge to move forward.

I mean, I'm looking at Kristal. I'm looking at Brian. I'm looking at Penny and Kit as the people in the room who might know.

COMMISSIONER CARTE: It's this potential in terms of impact is just so big. Like, Health Affairs had an article by a geriatrician last year or so and that geriatrician talked about finding a confused elderly person. They were a specialist in a large group practice.

They found this confused elderly person outside the practice one day struggling to get home, and they talked about how they went back to their fellow primary care provider and tried to suggest the tools, the assessments and things that might help this person. There's just been too little work done in this area, and yet we're sitting here talking about all the billions of dollars that are going to be spent to try to serve these people.

And, you know, when Dr. Butler and the other lady were speaking, Katherine, I'm thinking, why isn't there even just a simple fee that people can go to some public entity and get assistance when elderly people begin encountering these problems? There's no place to turn to. There's just no order to it at all, I mean, except for the very stark ones, like nursing homes. And, it's amazing to me that there's still states that don't even have home and community-based services. Amazing.

CHAIR ROSENBAUM: Kit, and then maybe we can talk about this a little bit more.

COMMISSIONER GORTON: So, I would wholeheartedly second what both Brian and Penny said. I guess I would put in my support for continuing to do this work as it matures.

I think it's important work. I think it answers important questions. And, I think Penny is absolutely right in terms of taking a broader view of the ecosystem and looking beyond the tools to the processes and the people that work together to get stuff done.

I would suggest that I would like to hear in future work the Commission try to answer two fundamental questions at least, one of which is, is it ever appropriate, and if so, when, to use the same tool to do eligibility assessment as to do care planning, because I think that's a critically important question and I think it's something that we should try and develop a point of view on.

And the second related question is, is it ever appropriate, and if so, when, to have the assessment, the care planning assessment performed by the provider of care, because I think that that's a place where there's wide variability in practice, and it's my impression, although, obviously, we should, as a Commission, validate this, the evolving best practice is, in fact, to separate those two. And, I think the Commission has something valuable to offer in terms of providing advice to states about how that could

be done, and I would facetiously suggest that it might be the source of an offset to deal with our CHIPRA --

[Laughter.]

CHAIR ROSENBAUM: Okay. Marsha --

COMMISSIONER BURWELL: Do you -- I have a technical -- do you consider a health plan a provider in this context?

COMMISSIONER GORTON: I do not.

COMMISSIONER BURWELL: So, okay. You mean a provider, a direct care provider.

COMMISSIONER GORTON: Correct.

CHAIR ROSENBAUM: Marsha.

VICE CHAIR GOLD: Yeah, briefly. I sort of -- I also think it could use a little tightening just to make the logic clearer throughout. In particular, the sort of set-up of the chapter as to why we're into this, I mean, we didn't just start looking at functional assessment tools. We must have had a reason for looking at them in some prior work.

And, then, I found it a little jarring on page 17 of our draft, and then it goes issues in moving to a national functional assessment tool. We hadn't set up -- I

mean, are we moving to it? Aren't we -- I mean, how did that relate to the motivation for the chapter?

And, so, I don't disagree with where you came out. I think it's -- I think it's really important to separate out the eligibility versus assessment, and I think the fact that we're dealing with a whole bunch of different subpopulations for which different needs exist, and the fact that CMS is still involved in a lot of experimentation means that it's premature to be thinking about things, and I don't even know what to think about. I don't know about standardized tools versus standardized data elements that would be available nationally that would allow you to understand better which eligibility -- you know, how the differences in eligibility split out.

So, I think, you know, mostly, it's here, but to whatever extent you can sharpen the logic, and I'm not sure where we go from here. I'm not sure -- I think we might think about who else does things, because some of it, to the extent it's trying to figure out what care people need, I mean, it may be clinical groups or groups who do measurement or groups who do care management that might be better positioned to look at some of these versus us. I

don't know. I'm not sure how big a priority it is for us to put a lot of resources into looking at this versus other issues we might look at. But, I think, you know, we need to leave it somewhere.

CHAIR ROSENBAUM: Yeah. I mean, I think that another way maybe of asking the question you're asking is what are the policy questions that MACPAC really has to try and get a handle on here? Obviously, it's above just the issue of the tools that are appropriate for the ecosystems in which you're functioning. It's what are the policy issues, and given those policy issues, what do we know and where do we need to go.

COMMISSIONER THOMPSON: Yeah, I think it's a little bit of like building on both Brian and then Kit as well, and responding also to, I think, the legitimate questions that Sharon is raising. It's this larger conversation around: What does it mean to do conflict-free, whole-person planning? What does it mean to be structuring programs for which there are criteria not just around income and category but also around function? And how do we ensure that once we enroll people in programs that we're delivering what they really need and people are

fulfilling those obligations?

I think something that helps us understand the map of that environment, and, you know, it may be a matter of people not having certain underlying science available to them to make proper decisions. It may be an issue of roles and responsibilities and whether the proper balance is struck. But I think that there could be a little bit of a fruitful at least exploration of the contours of that system to determine if there are things there that we want to continue to pursue.

CHAIR ROSENBAUM: Yeah, I mean, it really strikes me, you know, looking back on my roots in legal services, and knowing -- I mean, we had, of course, a version of this 40 years ago. It wasn't home and community-based care. It was long-term care. But it was --in institutions. But it was the same dynamic, which was you're dealing with people's eligibility for tremendously important benefits, and so the uncertainty and variability within systems of care within the state, from state to state, from disability to disability, not knowing really or understanding sort of the logic of the eligibility determination model or what benefits and services you would get raises, I mean, very

important policy issues as well as incredibly important practical and budgetary issues, so -- you know, and how in the end, tying us back to yesterday's opening discussion, when you look at what is driving the costs in the Medicaid program, coming up with a rational approach that is fair, that can be explained to people about the level of assistance you get. And we see states struggling with this, and so it's moving toward greater certainty and fairness that I think probably is sort of the bottom-line policy issue we're having to address here.

COMMISSIONER CARTE: Marsha, to go to your question, this partly came about -- and the rest of you who were here can help me recall. There was a commission for one year -- no, no, no.

COMMISSIONER COHEN: Long Term Care Commission.

COMMISSIONER CARTE: Long Term Care Commission for one year that came at the end of their one year, presented to MACPAC, they -- of all the work they'd done, they made one plea, and it was to look at this issue to try to go towards this. And I would still feel better if we were advancing the ball, even if it's to the Secretary of HHS, to say more has to be done here. Why do we have a

Center for Medicare & Medicaid Services Innovation? I mean, who -- they don't have the money to turn and study this issue or look at it? And we shouldn't say that there's a great need there?

CHAIR ROSENBAUM: Maybe it's an issue -- we will, of course, be doing our annual retreat in the late spring/early summer, and I think how we -- where we are on long-term care and how we grapple with it and what the Commission's role really ought to be, who we are advising and what we are advising about, you just can't help but have stuck in your mind, you know, the financial underpinnings of Medicaid and then the fact that we sit here and struggle with exactly where the right -- what's the right intervention for us.

Any other comments

COMMISSIONER BURWELL: I agree we need to open the aperture, but I think this is such a big area, it's hard to -- we have to kind of be selective. And two things which I really see as affecting this is MLTSS is definitely affecting it because it's changing the whole nature of who determines eligibility, how that's done, who makes the decision that this person meets the criteria or not, and

then also what benefits people get once they're in a plan and how that joint responsibility is shared between the plan and the state, because the state still has a role. I think that's a huge thing.

The other one is this kind of social determinants of health care thing. More and more plans, as they're getting into this, are -- I mean, I think there's a lot more flexibility around benefits and more plans providing those kinds of services that people were talking about. And so the assessment process is going beyond the need for LTSS services. It's getting to a much broader assessment of what's going on with this person and how can we support them. So there's a lot of evolution around that which affects this issue. So I don't know which way to go.

I guess the last thing, I'd like to hear from Leanna. I mean, you still hear from the consumer perspective that there's lots of silos, and people get multiple assessments, like people come to the door and are like, "I'm here to assess you." Like, you know, "There was somebody here three days ago. Who are you?" You know. And it happens more often than you'd like. So there's a whole -- I think things are getting more converged, but

there's still a lot of issues around this. It's very difficult.

COMMISSIONER GEORGE: Well, as a parent of two children, both get multiple assessments every three years from school systems, and then to have to with my daughter go through the assessments again or a different set of assessments for her home and community-based services waiver every two or three years because she's still a minor, I mean, it gets to the point that it's daunting because these evaluations, a lot of them are focused on my daughter's challenges. So, first off, for a parent, it keeps me dwelling -- there's so much that she can't do compared to her peers. And also there's just recently, even in North Carolina, with this whole thing about switching waivers and things like that, we just went through transitioning from one set of waivers -- or one set of testing to another set of assessments, from the SNAP to the CIS, and there's been a lot of hesitancy among parents about switching over because at first the CIS wasn't standardized for children, but now it is, thankfully. But just the whole questions like: Is this going to cause my child to lose services? How is that going to affect the

services my child receives, the scales and everything? Because now we're talking about tiered levels of support. I mean, it just really makes parents and caregivers of people who receive these services very anxious about what's going to change because of this new waiver or because of this new assessment that we're dealing with.

CHAIR ROSENBAUM: Which brings us back to the issue that this is the way that people secure the resources they need to be able to live in communities and thrive and grow if they're children and develop. And so while there are all of these obvious tremendously complex, technical and practical considerations in how one goes about making these decisions, I think it's important to remember that at the end of the day there is a decisionmaking process and there are real benefits for people, or not, out of it.

COMMISSIONER GEORGE: And one thing I do like about -- I had said what I do like about the states having their own process of developing their own assessments. A lot of states really pull local stakeholders, local consumers, and families into the mix, as well as professionals and other people, to be able -- well, this is what my life is, because, I mean, maybe you can't imagine

what I deal with every single day, you know, but it is what it is. And that's where -- that stakeholder group, the parents and the families, can contribute so much, and the individuals living with these as well can contribute to the development of their own assessments to help determine what they need.

CHAIR ROSENBAUM: Well, I think on that note, we couldn't end on a more focused note.

We do have time for public comment. Thank you, Kristal.

Any public comment this morning, on this topic or any other topic?

PUBLIC COMMENT

* [No response.]

CHAIR ROSENBAUM: Well, then we stand adjourned.

* [Whereupon, at 11:28 a.m., the meeting was adjourned.]