PUBLIC MEETING

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

Thursday, September 15, 2016
9:29 a.m.

COMMISSIONERS PRESENT:

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ALAN WEIL, JD, MPP

ANNE L. SCHWARTZ, PhD, Executive Director

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

2 [9:29 a.m.]

3 CHAIR ROSENBAUM: All right. We are going to
4 come to order. Good morning, everybody, and welcome to the
5 September MACPAC meeting. We have a very full day in store
6 for everybody. Because there is so much material being
7 covered, we have set up the day with two very substantial
8 briefings and then a public comment period following the
9 first two briefing sessions. And those two briefing
10 sessions, of course, deal with hospital payment issues.

11 We will then have a brief session on residential
12 care followed by another brief comment period. In the
13 afternoon we pick up with a session on beneficiaries with
14 serious mental illness and come back around to the question
15 of Medicaid financing, this time looking more generally at
16 the relationship between Medicaid financing generally and
17 provider payment policies.

18 There is a public comment period after that, and
19 then our final session of the day will be a review of
20 children's coverage and possible recommendations moving
21 toward a draft specifications package, followed by a final
22 public comment.

1 So a full day, and why don't we get started with
2 Chris Park.
3 ### **COMPARING MEDICAID HOSPITAL PAYMENT ACROSS STATES**
4 **AND TO MEDICARE**
5 * MR. PARK: Thank you, Sara.
6 As part of our payment work, we have frequently
7 been asked questions on how a state's hospital payments
8 compares to other states as well as how Medicaid payments
9 for hospitals compare to other benchmarks such as Medicare.
10 To address these questions, we worked with the Urban
11 Institute to construct a state-level payment index to
12 compare fee-for-service hospital payment
13 s, inpatient hospital payments across states, and to
14 compare Medicaid payments to Medicare.
15 Even though states have expanded their use of
16 managed care in recent years, fee-for-service payment rates
17 are still important to understand. Fee-for-service
18 hospital payments were about 18 percent of total Medicaid
19 spending in fiscal year 2014, and fee-for-service payment
20 rates are often the basis for the managed care plans'
21 payments to hospitals.
22 This work would be one of the first attempts to

1 do a comprehensive comparison of inpatient hospital payment
2 across states and is similar to the work that Steve
3 Zuckerman and his colleagues at the Urban Institute have
4 done for Medicaid physician services. We think that this
5 analysis can also serve as a foundation for MACPAC's future
6 work on payment adequacy and the relationship of payment to
7 measures such as access, value, and quality.
8 Today's presentation will go through the data and
9 methods used to create the payment index and demonstrate
10 how hospital payment can reflect a considerable amount of
11 variation in payment policies. I will then discuss the
12 steps we took to account for supplemental payment and
13 provider contributions in trying to assess net payment to
14 hospitals. And, finally, I'll present our comparison to
15 Medicare rates.
16 This work also links to our subsequent discussion
17 today on disproportionate share hospital payment policy and
18 the relationship between payment and financing.
19 In terms of creating the payment index, we used
20 2010 Medicaid analytic extract data. This was the most
21 complete set of data that we had at the time when we
22 started this analysis. The MAX data is a cleaned-up

1 version of the Medicaid Statistical Information System data
2 that we typically use for research purposes. We focused on
3 fee-for-service acute-care hospital stays for enrollees who
4 were under 65 and not dually eligible for Medicaid and
5 Medicare. We excluded the dually eligible since Medicare
6 would have been the primary payer for most of their
7 hospital stays. We excluded those eligible on the basis of
8 age as the majority of these individuals were dually
9 eligible, and the remaining population of non-dually
10 eligible enrollees resulted in small sample sizes in most
11 states.
12 We additionally excluded stays for
13 rehabilitation, long-term care, and psychiatric hospitals
14 to further reduce variability across states in terms of
15 payment associated with different hospital types. And,
16 finally, we excluded managed care stays because the MAX
17 data do not contain payment information on how much the
18 managed care plans paid providers.
19 Because states use different payment
20 methodologies to pay for inpatient hospital services, such
21 as per diem, cost basis, and diagnosis-related groups,
22 there is not a set of standard billing codes used across

1 all states, so we needed a consistent and comparable way to
2 identify what condition was being treated and what services
3 were being provided during a stay across all states. To do
4 this, we classified all of the claims from all the states
5 using the All Patients Refined Diagnosis Related Groups, or
6 APR-DRGs. We also made adjustments to control for price
7 differences across markets and differences in enrollee
8 characteristics and case mix.
9 We made a wage adjustment to account for
10 differences in local prices and wage rates across and
11 within states, and we used the Medicare methodology to do
12 this. So we used the local wage index data from CMS'
13 Inpatient Prospective Payment System and the hospital labor
14 share to make this adjustment.
15 We also made a case mix adjustment to control for
16 differences in the mix of enrollees and the acuity and
17 severity of admissions across states. The details are on
18 this slide that I won't necessarily walk through in great
19 detail, but one way to think of this is analogous to risk
20 adjustment, so we are trying to control for the different
21 populations across states.
22 To construct the payment index, we calculated

1 wage and case mix adjusted average payment per state for
2 each state. Then we divided each state's average payment
3 amount per state for all states -- we took the average
4 payment amount for each state and divided it by the average
5 payment amount for all states. So this created an index
6 value which provides a relative value compared to the
7 national average. For example, if the index value in a
8 state was 1.10, that means it was 10 percent higher than
9 the national average.
10 This graph shows the results from our payment
11 index, and the payment index ranges from 0.49 in New
12 Hampshire to 1.69 in Washington, D.C. While this is a wide
13 range, I should note that the most recent Zuckerman study
14 on physician fees also showed a very wide range in payment
15 rates, ranging from 0.57 in Rhode Island to 2.54 in Alaska.
16 So this isn't necessarily an uncommon distribution across
17 states.
18 Because our payment index focuses on average
19 payment, it masks some of the considerable variation in
20 payment policies and amounts within any given state. There
21 are variations in state payment policy within a state,
22 which means that states are not consistently high or low

1 payers across all conditions and services. Some states
2 have made specific policy adjustments to increase or
3 decrease payment for particular services to support policy
4 goals. For example, Tennessee and Washington have lowered
5 payment for cesarean deliveries in recent years as part of
6 initiatives to reduce C-sections and early elective
7 delivers.
8 Additionally, state payment for a particular
9 condition may vary across hospitals. This payment may vary
10 by hospital because the payment methodology is inherently
11 hospital-specific, such as a cost basis, or the state
12 assigns hospitals different base rates under a DRG-based
13 methodology.
14 To take a closer look at this in-state variation,
15 we selected a sample of 20 high-volume, high-dollar DRGs
16 and severity subclass combinations. We calculated a wage-
17 adjusted payment index for each of the 20 APR-DRGs, and we
18 didn't have to do a case mix adjustment in this process
19 because each of the APR-DRGs are inherently case mix
20 adjusted because they are for a specific condition and
21 severity.
22 So here we show the correlation coefficient

1 between the 20 individual APR-DRG indices compared to the
2 overall base payment index, and we use this to try to judge
3 how well each of the different conditions compared to the
4 overall payment index. And for the most part, most of the
5 20 APR-DRGs had a moderate to fairly strong relationship to
6 the overall payment index based on the correlation
7 coefficient being over 0.5.
8 However, there were exceptions, and here we just
9 show a few examples of how the overall index compares to
10 three different conditions of appendectomy, diabetes, and
11 cesarean section. And we left the states de-identified at
12 this point because we just want to show examples of how
13 this variation across states and within states can take
14 place, and we didn't want to focus on any particular state
15 at this point.
16 For example, State A here was a fairly high payer
17 on the overall index with a state ranking of seven, which
18 means that they were the seventh highest paying state on
19 average. But as you can see in the circle sections, they
20 were fairly low for appendectomy and cesarean section.
21 State B was in the bottom third of payers in
22 terms of the overall index, but they were fairly high on

1 diabetes.

2 State C, you kind of see how they were both high
3 on appendectomy and low on diabetes compared to their
4 overall rank.

5 And then State D was very low on almost all the
6 services, but they were fairly high -- like around the
7 middle -- for appendectomy.

8 This slide shows a box and whisker plot that
9 shows the variation of payment within a state for a
10 particular service. So in this case, we are showing an
11 example of the cesarean delivery payment. And so the
12 rectangle showed the 25th to 75th percentile range of
13 payment. And so you can see from the two states that I've
14 circled in red how wide this payment range can be in
15 certain states, versus, you know, here kind of circled in
16 dark blue for Indiana and Michigan, you see a very tight
17 range, which means that they don't have much in-state
18 variation across hospitals for this particular service.
19 And so, you know, you can see how these 25th to 75th
20 percentile ranges overlap across states and how for certain
21 states the hospital distribution mix that you capture
22 within the time period you are analyzing can make a great

1 difference in how their average payment would come out.

2 So all the comparisons I've shown you so far have
3 focused on the base payment made to hospitals through the
4 claims process system. This ignores the supplemental
5 payments to hospitals, and these supplemental payments are
6 substantial. In 2014, about 44 percent of total hospital
7 payments were made through supplemental payments, and these
8 are frequently made on a lump-sum aggregate basis, and
9 claims data in the MAX information that we had did not
10 contain the information for supplemental payments.

11 While we do have information on the aggregate
12 amount of supplemental payments at the state level through
13 the CMS-64 Financial Management Report, we do not have good
14 information on the amount of supplemental payments made to
15 individual hospitals.

16 Another challenge associated with supplemental
17 payments, they're frequently used with non-federal
18 financing options, such as provider taxes, certified public
19 expenditures, intergovernmental transfers. And so because
20 the provider is contributing a portion of the non-federal
21 share, we need to take these into account to get to a net
22 payment that these providers actually receive once you

1 remove these provider contributions.

2 As I mentioned before, we have state-level
3 supplemental payment data from the CMS-64 Financial
4 Management Report. However, not all states consistently
5 break out the supplemental payments to hospitals. They may
6 report in one lump sum for both base payments and
7 supplemental payments. So this makes a comparison
8 difficult because, depending on how the state reported the
9 data, you may get different results. So we created two
10 different methodologies to try to take supplemental
11 payments into account.

12 The first methodology grosses up the base payment
13 from MAX to match the CMS-64 total in aggregate. And so
14 this makes an adjustment even if the state doesn't report
15 supplemental payments separately. However, this
16 potentially grosses up base payments as well even if a
17 state did not make a supplemental payment.

18 The second method grosses up base payments in MAX
19 using a ratio of total inpatient payments to regular
20 inpatient payments in the CMS-64. One of the benefits of
21 this is it keeps the claims payment amount the same from
22 the MAX. However, it doesn't work well if the state does

1 not report supplemental payments separately. And because
2 we're using state-level data, we make both of these
3 adjustments equally -- you know, the same factor gets
4 applied to all hospitals and all cases that we have in our
5 data.
6 Because of the supplemental payment adjustment,
7 we ran four different scenarios. The first scenario is the
8 unadjusted base payments, which I just showed you.
9 Scenario 2 and 3 are the two different supplemental payment
10 methodologies that I just walked through. And Scenario 4
11 takes Scenario 3 and tries to calculate net provider
12 payment by backing out provider contributions using data
13 from a 2014 GAO study.
14 So this slide just shows you how the adjustment
15 and assumptions that we make really matter across states.
16 We're looking at the four different scenarios for six
17 different states. And so State A here was the highest-
18 ranked state on the base payment scenario, and once you
19 make the adjustments, you know, they come out to be seventh
20 on the net payment scenario. But, you know, they are in
21 the teens for the two different supplemental payment
22 adjustments.

1 State B is kind of the opposite. They were near
2 the middle on the base payment scenario, but once you take
3 net payments into account, they were ranked number one.
4 States C and D are just kind of some of the
5 average cases where they have some variation across the
6 different scenarios, but they maintain a kind of same
7 relative position among states.
8 State D was just kind of the lowest on both the
9 base and net payment scenario.
10 States E and F really show the effect of the two
11 different supplemental payment methodologies. As you can
12 see, State E was near the bottom under Scenario 2 but near
13 the top under Scenario 3, and vice versa for State F. They
14 were near the top for Scenario 2 and near the bottom for
15 Scenario 3. So because of our lack of data at the provider
16 level and the assumptions we are making, the methodology
17 does make a big difference.
18 So the other question we are frequently asked is
19 how Medicaid payment compares to other payers such as
20 Medicare. And so to make this comparison, we used the fee-
21 for-service Medicaid stays for non-elderly adults eligible
22 for Medicaid on the basis of disability. We wanted to

1 limit the population by taking out the children and
2 pregnant women and other adults who are less like the
3 Medicare population.
4 We also classified the Medicaid claims using CMS'
5 Medicare DRG group or the MS-DRGs, and we did this so that
6 we could match -- make a closer match to how CMS classifies
7 and pays for stays.
8 We got the Medicare payment from CMS' Medicare
9 provider utilization and payment data set that they've
10 released, and we used the inpatient data for fiscal year
11 2011. We used the average total payment from this data
12 set, and this data set contained payment information for
13 the top 100 most frequently billed Medicare MS-DRGs by
14 provider.
15 From this list of the top 100 DRGs, we focused on
16 18 high-volume MS-DRGs for both Medicaid and Medicare, and
17 we also included hospitals that are in both data sets due
18 to some of the variation across hospitals that I mentioned
19 earlier. We wanted to try to make this comparison as close
20 as possible by looking at the specific conditions and
21 specific hospitals that were comparable across both data
22 sets.

1 And we also weighted the Medicaid payments by
2 Medicare volume at the hospital MS-DRG level to calculate,
3 you know, a total national payment across the same mix of
4 services and hospitals. By doing this, we found that
5 Medicaid base payments were, on average, at the national
6 level 78 percent of Medicare.
7 However, this is a bit misleading because the
8 Medicare payment was the total Medicare payment and
9 contains the supplemental payments that are made in
10 Medicaid, such as Medicare DSH and GME amounts. All of
11 these are paid through the inpatient prospective system and
12 so were included in the total amount that we're able to get
13 from the CMS data set. However, we haven't made our
14 adjustments on the Medicaid base payment side, so none of
15 the non-DSH or DHS supplemental payments have been taken
16 into account at this point.
17 This graph kind of graphs the average Medicare
18 payment on the X-axis versus the average Medicaid payment
19 on the Y-axis, and the diagonal line kind of distinguishes
20 where Medicaid or Medicare is a high payer. And so
21 anything below that diagonal line indicates that Medicare
22 is a higher payer than Medicaid. And so as you can see

1 here, the Medicaid base payment was lower than Medicare for
2 all 18 MS-DRGs that we looked at.
3 At this point we applied the supplemental payment
4 and provider contributions adjustments from the payment
5 index scenarios that I mentioned earlier, and we used
6 Scenario 4 to get to the net payment amount.
7 Applying those assumptions, we found that
8 Medicaid net payments at the national level were about 6
9 percent higher than Medicare, and this result is similar to
10 results from the American Hospital Association survey that
11 has shown that Medicaid has a higher payment-to-cost ratio
12 than Medicare since 2010.
13 Of course, you know, this doesn't apply across
14 all of the 18 MS-DRGs we looked at. You can see here I've
15 layered on the Medicaid base payment amount -- the net
16 payment amount on top of the graph that I showed earlier
17 for the base payment, and here two MS-DRGs were still --
18 Medicaid was still lower on two MS-DRGs than Medicare. But
19 on 16 they were higher.
20 So from this analysis, we found a few key
21 takeaways. First, Medicaid inpatient hospital payment
22 varies widely both across states and within a state.

1 Overall, Medicaid net payment is comparable or higher than
2 Medicare.
3 There were substantial challenges in doing this
4 analysis, and it demonstrates how complicated it can be to
5 calculate Medicaid payment for inpatient services and make
6 comparisons to other states and benchmarks. You know, one
7 of the main challenges is due to the supplemental payments
8 and the financing, and that challenges our ability in any
9 subsequent analysis to link payment to other measures such
10 as access, quality, and value.
11 It also confirms the Commission's prior
12 statements on the need for additional payment on financing
13 and supplemental payment at the provider level, so we can
14 do a better assessment of how individual providers are
15 being paid and not have to make as many assumptions.
16 So at this point we would appreciate any comments
17 from the Commission on the results of this analysis and any
18 potential areas for additional work. We'd also appreciate
19 any thoughts you have on how we may disseminate this
20 information. It could be a stand-alone document or
21 included in one of MACPAC's future reports to Congress.
22 CHAIR ROSENBAUM: Thank you, Chris.

1 I wonder if I could ask Sheldon to lead us off
2 and then followed by Toby, Andy, Stacey. Alan is not here
3 yet. Okay.
4 COMMISSIONER RETCHIN: Thanks, Sara.
5 Great job, Chris. I really appreciate the
6 analysis.
7 You know, while you were going through this --
8 and, actually, in observations previously -- it's an
9 interesting conclusion that I come to when I compare
10 hospital and physician payments. So let me just ask if you
11 think this is true as I go through this, because one of the
12 references or citations in this was with Zuckerman's
13 analysis of physician payment, when in fact that was really
14 an analysis of primary care only.
15 Prior to that, Zuckerman had looked at physician
16 fees across specialties, across states on Medicaid. So the
17 observation I would make, assuming the analysis holds true,
18 is that Medicaid, as a matter of policy, pays more than
19 Medicare for hospitals. Is that a conclusion I can draw?
20 When you take into account all -- the supplemental payments
21 that we can measure.
22 MR. PARK: Based on the analysis so far, given

1 all the assumptions we've made, it does look like for
2 inpatient hospital services, Medicaid does pay higher than
3 Medicare, kind of at the national level. Of course --
4 COMMISSIONER RETCHIN: There are a lot of
5 variations, and there are caveats to that.
6 MR. PARK: Yes.
7 COMMISSIONER RETCHIN: Flip that around, and
8 actually, this should ring true for the other
9 Commissioners, that Medicare pays higher for physician
10 services or provider services than Medicaid.
11 MR. PARK: That appears to be the case based on
12 the Zuckerman study.
13 COMMISSIONER RETCHIN: And that's why I keep
14 coming back to this. For the Medicaid population, it would
15 be difficult, if not impossible, to achieve an adequate
16 physician workforce for the Medicaid population, unless
17 there was something else going on, whether the physicians
18 are employed or they're in some way able to make up the
19 difference through other arrangements. And that's what I
20 think is missing when we analyze this. Anyway, it's just
21 an observation.
22 Other than that, I do think when you're comparing

1 MS-DRGs -- we discussed this -- it gets a little difficult
2 across different payers like Medicaid and Medicare where
3 you're dealing with such different populations, albeit you
4 tried by eliminating some of those that would contaminate
5 the analysis. Whereas, with physician fees that are
6 largely E&M, those are pretty comparable. So it's just an
7 observation.
8 CHAIR ROSENBAUM: Can I just ask, Sheldon, are
9 you suggesting that one thing we might want to know more
10 about is how Medicaid hospitals use the revenues they
11 receive compared to hospitals when they're billing for
12 Medicare patients? When hospitals are billing for Medicaid
13 patients, they may take on a greater range of activities or
14 scope of activities with what they do as hospitals versus
15 what they might be doing for the Medicare patients?
16 COMMISSIONER RETCHIN: And I keep coming back to
17 this. I don't know how we would analyze that other than
18 case studies, but I think it's undeniable, and from that I
19 see in the marketplace, it would be -- when you're looking
20 at payment rates for physician that -- average in
21 California at one time, it was less than 60 percent of
22 Medicare. It would be virtually impossible for them to --

1 inadequate workforce. So, yeah, I am suggesting that's a
2 very important observation from a policy standpoint.
3 CHAIR ROSENBAUM: Toby.
4 COMMISSIONER DOUGLAS: First of all, great
5 analysis. It's just really, really useful information.
6 Just building on some of the points you made, I
7 definitely think we need to understand more at the provider
8 level, what's going on. There's no question that this
9 gives us a good sense on the aggregate across states and in
10 a state, but just understanding what's going on among
11 hospitals. And I know that's so difficult, but it's
12 something we always have to keep in account.
13 The other, I would build on what Sheldon said. I
14 think the point that the rates are at or above Medicare on
15 average, comparing that, doing some type of analysis that
16 looks at the physician side, and brings these two analyses
17 together to raise questions, what are we seeing in states
18 on investment in hospital versus physician services? What
19 policies are potential to deal with the fact that we're all
20 trying to reorganize care? And whether it's through
21 investments or financing incentives that look at the fact
22 that one state that might be at 110 percent of Medicare on

1 inpatient is at 60 or 70 percent of Medicare on physician
2 services, and are there ways to assess that or at least
3 bring it together? So we're seeing that.
4 The only other question I have -- and this is
5 more just from a Medicaid policy. The upper payment limit
6 is supposed to be Medicare for hospitals. So what is going
7 on here is just an interesting question. Penny would be
8 coming to me and saying, "What's going on here?"
9 [Laughter.]
10 COMMISSIONER DOUGLAS: So I'll leave it at that.
11 MR. PARK: Yeah. Just to address that last
12 point, the upper payment limit is based on Medicare payment
13 principles and not necessarily what Medicare would have
14 necessarily paid at that particular point in time. So
15 there could be some areas where a state may be used, like a
16 cost-based Medicare payment methodology. There are
17 different ways to calculate the UPL, and it's not exactly
18 the payment.
19 COMMISSIONER DOUGLAS: I think we might need to
20 put something like that in the paper, just to make that
21 clear --
22 MR. PARK: Okay.

1 COMMISSIONER DOUGLAS: -- so we don't have --
2 that it doesn't cause a lot of problems with the underlying
3 policy. It's not that CMS or states are disregarding the
4 policy, but we need to understand what goes underneath
5 that.
6 CHAIR ROSENBAUM: Andy.
7 COMMISSIONER COHEN: Really interesting work.
8 Thank you for a great analysis.
9 I wanted to ask a question to make sure that I'm
10 understanding something correctly and then maybe just go
11 back to the big-picture point -- two points that have
12 already been raised.
13 So the question is this. On the Slide 24, that
14 shows Medicaid net payment for MS-DRGs. I guess I'm a
15 little confused about how you can talk about net payment
16 for a DRG because I thought the whole issue here is that
17 you have base payments that are per something, service day,
18 something like that, person stay, admission, discharge,
19 whatever, and then you have supplemental payments that are
20 not necessarily connected to service, stay, discharge,
21 admission, whatever it is. And so how you do -- and I just
22 want to make sure I understand. Presumably, this was a

1 calculation, but it doesn't actually reflect that there is
2 -- you can't have a net payment that includes supplemental
3 payments per, say, using the standard of an MS-DRG.
4 MR. PARK: That's correct.
5 COMMISSIONER COHEN: Okay.
6 MR. PARK: You have pointed out a lot of the
7 limitations of what we've been able to do so far because we
8 are using state-level data to make these factors that, as
9 we've seen, payment can vary by hospital. It can vary by
10 MS-DRG. We're applying the same factors equally to each
11 hospital and to each Stay, and so you're right in that this
12 may not show the true variation on net payment based on how
13 -- like a particular hospital may choose to distribute the
14 funds they receive in supplemental payments.
15 COMMISSIONER COHEN: It is interesting. I mean,
16 there has obviously been discussion and rhetoric about the
17 issue of Medicaid payment to different kinds of providers
18 for years, and this is like a tremendous contribution to
19 that discussion, a fact-based contribution to that
20 discussion.
21 But I think I just want to say some sort
22 interpretative things and restate what some other people

1 have been saying. What this tells us is how much Medicaid
2 across states in the aggregate is paying to an industry
3 compared to Medicare. It is not suggesting that every time
4 a Medicaid payment goes to any given hospital in any given
5 place that that payment is higher than if that patient had
6 been a Medicare beneficiary. We really have -- we have no
7 idea, and in fact, the only thing we know for sure,
8 relatively for sure, is that in many -- actually, most
9 states, the actual payment that goes along with that
10 particular district, whatever you want to call it,
11 admission is less than what they would have gotten for
12 Medicare. It's the supplemental payments that makes a huge
13 difference, but we have no idea what the -- we know little
14 about what the distribution is of those things. So you
15 just have to make sure that we're interpreting this about
16 sort of payment to an industry as opposed to making some
17 assumptions about what a particular hospital is receiving
18 associated with any particular patient and payer mix. So
19 that's one thing that I just want to say interpretively.
20 And I think the other point that Sheldon has
21 raised and just sort of goes to the complication of all of
22 this -- so we know about what we pay for an industry as

1 compared to Medicare. We certainly don't know that
2 Medicare gets it right necessarily in terms of like how
3 resources should be allocated across outpatient, inpatient,
4 different kinds of things. But we do know that Medicaid
5 varies from -- higher for inpatient, higher in the
6 aggregate in terms of total use of resources for inpatient,
7 lower for outpatient. And that's important for us to think
8 about, considering where the whole trend in population
9 health and the need to address costs where hospitalizations
10 are often a very high cost. We still see that overall,
11 incentives are sort of higher for use of inpatient services
12 in Medicaid, or they're paid a little bit better relatively
13 than outpatient. I think that's an important insight that
14 we need to think about.

15 But the other thing is that now, of course, many
16 hospitals are actually now systems that provide a lot of
17 outpatient care, too, and do cross-subsidization within
18 their own system. So whatever they're bringing in on the
19 inpatient side, they may be cross-subsidizing within their
20 own system, outpatient, for it. So we just have to sort of
21 remember that our world is not clean. We don't have
22 entities that only do -- we have very few entities that

1 only do an inpatient business anymore, and a lot of the
2 blending of payment and other things happens within a
3 system. And that's obviously very complicating because,
4 changing payment on inpatient, for example, may end up
5 having a very different -- you know, once it goes through a
6 set of decisions inside a system, for example, the
7 implications might be a reduction in outpatient services.
8 CHAIR ROSENBAUM: Thank you. Thank you. Stacey?
9 COMMISSIONER LAMPKIN: So thank you. I want to
10 say this is a remarkable start to adding a significant
11 amount to our knowledge base, and it's hard to do too. As
12 somebody who dipped my toe in trying to do something like
13 this on a much smaller scale a few years ago, the technical
14 challenges are not trivial with trying to make this
15 comparison. So I want to thank the team for that.
16 The biggest takeaway from this is how challenging
17 it is that we cannot get supplemental payment information
18 at a provider level. It's out there. I know I'm not the
19 first. I'm speaking to the choir, but it just really is a
20 critical thing that we need to try to complete this
21 picture.
22 We also need to include managed care perspective,

1 as soon as that's practical, with good idea.

2 I would like to see us move to something we could
3 publish on this. I think we have to be careful about what
4 we say, and some of what we're doing is great for
5 illustrating the problem with not being able to get the
6 supplemental data at the individual level, but we need not
7 to overreach in what we can say.

8 So, in particular, I was a little concerned about
9 this graph right here, in fact, in taking the base payment
10 comparison up to a supplemental or a net supplemental, just
11 because of the allocation and the difference in case mix at
12 the facility level that could skew something like this,
13 because we're taking a fairly narrow picture, as I
14 understand it, of disabled adult inpatient stays where we
15 have both high Medicaid and Medicare utilization and
16 focusing in on that, which may skew our facility mix a
17 little bit.

18 The other thing I wondered, Chris, is -- and,
19 again, related to what we can compare fairly to Medicare.
20 Is there something we can use that as a baseline to be able
21 to say about obstetric or pediatric care, which is a lot of
22 the core population where we can't maybe fairly benchmark

1 it to Medicare? But if we have a baseline to Medicare, can
2 we then show, relative to that baseline, how states are
3 paying in these other areas? And I don't know the answer
4 to the question. I just think it would be helpful in our
5 big-picture understanding of how the hospitals are paid, if
6 we can get to something like that.
7 MR. PARK: Yeah. I think we might be able to do
8 something using the relative weights that CMS has created
9 for the MS-DRGs. So that even though there might not be a
10 lot of payment information on deliveries in Medicare, we
11 could see that relative weight compared to kind of the
12 average MS-DRG payment and extrapolate to what a payment
13 would be for delivery under the MS-DRG system.
14 COMMISSIONER LAMPKIN: I think that would be
15 helpful.
16 Then my last comment on this, as we move to
17 something that we would publish, if we can identify states
18 at least in appendices -- I understand the point of the
19 blinding here was illustrative, but I think it pairs very
20 nicely with the material that we've published on the state-
21 specific inpatient payment methodologies and to be able to
22 put those two side by side. Great contribution, so thank

1 you.

2 CHAIR ROSENBAUM: Marsha.

3 I wonder whether Alan might want to get settled.

4 Are you set to talk? We had you down as maybe wanting to

5 weigh in on this.

6 COMMISSIONER WEIL: Yes. Thank you. But,

7 actually, I love the data, and I love the points that have

8 been made, and I think I mostly want to echo Stacey's last

9 point, which is that this is incredibly difficult. The

10 contribution here is tremendous, but there are a lot of

11 limitations that we just have to be really careful of as we

12 move forward. So I'll leave it there. Thank you.

13 CHAIR ROSENBAUM: Marsha.

14 VICE CHAIR GOLD: Yeah. Hi. Great discussion.

15 Great work.

16 I had also some related to points I've heard, but

17 in terms of putting out the material and thinking about

18 some of the comments, one, it would be useful if there's a

19 way to do it to get a sense of what share of either

20 Medicaid inpatient admissions or revenue or something is

21 included in this analysis, because it excludes managed

22 care. And, in some states, that could be quite a bit,

1 although a lot of times, the SSI and things are not in it.
2 So, probably, compared to people, it's a larger share of
3 inpatient admissions is picked up in your analysis, but if
4 there's some way to get a sense of how important this is
5 vis-a-vis what we can't see.
6 Second, on the outpatient point that Andy brought
7 up as well and others, I think that's really key in terms
8 of dealing with some of Sheldon's concerns and others
9 concerns, because it isn't just you have a physician office
10 and you have an inpatient hospital. Increasingly, there's
11 a lot of -- and for Medicaid always, there's always been a
12 lot of outpatient care that's billed through the hospital,
13 and it would be useful to understand if some of the
14 differences carried over or not to the outpatient area than
15 others. If they do, it gives an incentive for the hospital
16 to internalize physician functions and adds to cost.
17 So I think if we're comparing physicians and
18 hospitals, we have to really build in the fact that we
19 don't cover -- and it's important to cover -- the share
20 that is outpatient that occurs through the hospital and is
21 billed through the hospital and the incentives there.
22 And the third ting, which is really just a

1 question, you have allocated all the extra payments to the
2 inpatient side, I think. Does that mean we've overstated
3 that it potentially overstates Medicaid payments relative
4 to Medicare, or are these really inpatient payments, not
5 total hospital payments?
6 MR. PARK: So the CMS 64 data that we use does
7 have the ability for states to report inpatient
8 supplemental payments versus outpatient supplemental
9 payments. Most states say the majority of their
10 supplemental payments in hospitals are for inpatient
11 services.
12 To Andy's point, once it gets to the hospital, we
13 don't know how they use the dollars.
14 VICE CHAIR GOLD: But they're reported as
15 inpatient.
16 MR. PARK: Yes.
17 CHAIR ROSENBAUM: Good. Kit, and then Penny and
18 then Brian.
19 COMMISSIONER GORTON: So just quickly echoing
20 what everybody else has said, I think this is important
21 work. I do think we should move forward to reporting it
22 somehow, and I agree with the folks who have said that at

1 that point we should probably unmask it, because I think
2 it's important data for state decisionmakers to know where
3 they stand and be able to benchmark themselves against
4 others. They may continue to make the choices that they're
5 making, but we ought to at least help them make informed
6 choices.

7 A couple of things, sort of following up on what
8 Marsha was saying about managed care. I do think you need
9 to figure out some way to adjust some of these data for
10 managed care impact. If we go back to the distribution
11 graph on Slide 8, Connecticut it looks to me is sitting at
12 about 0.85, Massachusetts at about 1.05, and Rhode Island
13 in the middle at about 0.95. We know we've seen data from
14 other sources that suggests that Rhode Island is a higher
15 payer.

16 What I would say to you is Connecticut has no
17 Medicaid managed care based on a policy decision that the
18 current administration made. Massachusetts actually has
19 about 50 percent. And Rhode Island has bet the farm on
20 managed care, and about 90 percent of their Medicaid
21 population -- and it's a growing percentage -- is in
22 managed care.

1 I think it's a generally accepted observation
2 that the managed care plans often have to -- always have to
3 pay at least what Medicaid, the state agencies, are paying
4 and often have to pay some inflator on top of that. So by
5 missing the amount of care that's delivered in the managed
6 care setting -- I mean, I think if you took Rhode Island
7 and said, okay, pick a number, the plans are paying 105 to
8 110 percent of state Medicaid, but 90 percent of the care
9 is -- I think on your index, Rhode Island goes up a bit.
10 And so I do think you need to figure out a way to model an
11 adjustment for that -- I guess building on what Marsha was
12 saying -- that allows you to figure out effectively what
13 the state is paying across all of its payment
14 methodologies.
15 VICE CHAIR GOLD: I don't know how feasible that
16 is because managed care data [off microphone] --
17 COMMISSIONER GORTON: I'm not suggesting you
18 build it off of managed care data. I'm suggesting that
19 what you do is you come up with some adjustment, which I
20 think would be rough, that says that you need to assess
21 Rhode Island differently from Connecticut and you figure
22 out how to weight that. You know, I'm not an actuary, I've

1 never played one on TV, but I do think that we want to
2 think about that.
3 And I think at the very least it needs to be
4 spoken to, and that gets me to my second point, which is
5 that I do think there's an opportunity to do some
6 qualitative and descriptive work about how the plans in the
7 current state are paying their hospital providers,
8 everything from quality incentives to percent of premium
9 deals to shared savings arrangements. You know, CMS has
10 been pushing hard over the last 5 years to try and move
11 people in the direction of alternative payment
12 methodologies. Most states do collect data from the plans
13 about what percentage of their networks, you know, are in
14 alternative payment methodologies. Massachusetts and some
15 other states actually publish those data. CHIA has just
16 put them out for Massachusetts in the last month. And so I
17 do think it's worth talking about how states may, in fact,
18 use the managed care programs to push money out and to
19 shape care.
20 And the final point is to what Andy was saying,
21 which is sometimes there are trade-offs. Sometimes we
22 might decide to feather back funding on inpatient in order

1 to push funding out to primary care or to push -- you know,
2 a big push, can we push funding out to behavioral health?
3 And so I do think there's room, in addition to these data,
4 which are very important and should be put out there, to do
5 some really fairly high quality descriptive work that sort
6 of sets it...
7 CHAIR ROSENBAUM: Before going to Penny and
8 Brian, can I just note the importance of what you raised
9 about the managed care payment policies -- and I do not
10 want to take time on it now -- but any thoughts you have on
11 how we might get those data, because they are treated as
12 proprietary.
13 COMMISSIONER GORTON: Sure, I'm happy to take it
14 offline. But there are some ways that one could get data
15 that would be informative.
16 CHAIR ROSENBAUM: Okay.
17 COMMISSIONER THOMPSON: I'll be quick because I
18 know we're at the end of this. This is fantastic and great
19 conversation.
20 I just wanted to sort of follow up on this
21 question about the supplementals and then the net payments.
22 One is appreciating on the supplementals. Part of this

1 makes me wonder whether or not we do have enough data here
2 to really publish an analysis that's meaningful if we're
3 missing almost 50 percent of the dollars that are being
4 paid out under fee-for-service because of the supplementals
5 and how we could address that.
6 The other point is sort of similar to what Andy
7 raised, which is it's my belief that the payment of the
8 supplementals is highly variable in the class that we're
9 looking at. And so the impact of that, we've sort of
10 spread it out across an entire group of payments, and it
11 probably doesn't really look that way and probably doesn't
12 even closely look that way.
13 And then the other point is just asking you,
14 Chris, about this calculation of a net payment, which is
15 taking off provider contributions and just -- we'll
16 probably get in this later today. I just want to
17 understand the thinking behind that, which is that's a cost
18 to providers, but there are lots of costs to providers.
19 And so can you just say a little bit about why you think
20 that measure is meaningful?
21 MR. PARK: Sure. I think one reason is that when
22 we're making the supplemental payment adjustment, we're

1 adding in a substantial amount of dollars, and a lot of
2 those supplemental payments are specifically tied to, as a
3 class, the hospitals contributing some of that money. And
4 so if we make that supplemental payment adjustment without
5 taking into account that those payments would probably not
6 have happened unless the hospitals contributed a portion of
7 that money, I think we would be overflating the impact of
8 the supplemental payments for the providers' net inpatient
9 revenue because -- and if those costs are specifically tied
10 to, you know, the payment that they ultimately receive in
11 supplemental payments, where other costs are kind of spread
12 across payers, you know, there's allocation going on, but,
13 you know, it doesn't -- you know, one particular hospital
14 under like a DRG payment system has higher costs for plant,
15 the building and rent and stuff like that, that doesn't
16 necessarily mean that their Medicaid payment is going to be
17 higher. But in this case, there is a more direct link
18 between the amount the provider contributed and -- you
19 know, if they didn't contribute any of that money, they
20 might not get a supplemental payment in aggregate.
21 COMMISSIONER THOMPSON: Right. Well, I don't
22 want to go down this rabbit hole here. I mean, we'll

1 probably go down this rabbit hole later today. But I would
2 put a pin in that question because, of course, by law they
3 cannot be tied.
4 MR. PARK: Yes.
5 COMMISSIONER THOMPSON: And so I just want to be
6 -- you know, there is certainly -- without revenue, you
7 don't create the program, but that doesn't mean that the
8 revenue and the program are completely one-to-one.
9 MR. PARK: That is correct.
10 COMMISSIONER THOMPSON: Okay.
11 COMMISSIONER DOUGLAS: Can I follow up on that?
12 We can talk about -- I'm really glad, Penny, you raised
13 this, and I have to say that the more I think about it, I'm
14 very concerned about using this net. I think we really
15 need to think it through, because I think it's actually
16 making a policy judgment and the underlining principles of
17 Medicaid financing.
18 CHAIR ROSENBAUM: [off microphone] an attribution
19 that may not exist.
20 COMMISSIONER DOUGLAS: Well, yeah, isn't that
21 what we're saying, is it's not -- in certain ways it gets
22 to the question is that a legit -- non-federal share.

1 COMMISSIONER BURWELL: So a clarification
2 question. On the Medicaid side, we chose to select the
3 Medicaid disabled population only.
4 MR. PARK: Yes.
5 COMMISSIONER BURWELL: On the Medicare side, do
6 we use the entire Medicare population or just the disabled
7 population?
8 MR. PARK: We use the entire Medicare population.
9 The data we have was aggregated at the hospital and MS-DRG
10 level, so we did not have the ability to make any
11 population adjustments on that side.
12 COMMISSIONER BURWELL: Do you think that might
13 make any difference?
14 MR. PARK: I think it could make a difference,
15 but because we're looking at specific MS-DRGs and
16 conditions, I think that does reduce a lot of the
17 variability that might occur on the population if you have,
18 you know, like a coronary artery bypass graft, you know,
19 that in itself kind of equalizes the population somewhat
20 because they have the same condition and are receiving
21 similar services. And so I think whether you're disabled
22 or non-disabled at that point is a secondary factor, you

1 know, in terms of looking at the payment for that
2 particular service versus the condition you actually have.
3 COMMISSIONER BURWELL: My second question relates
4 to Table 2, which is the differences in the index across
5 types of DRGs within a state.
6 MR. PARK: Yes.
7 COMMISSIONER BURWELL: I just find that data
8 perplexing, how a state can vary so much dramatically from
9 condition -- you would think that Medicaid payment to
10 hospitals would be relatively consistent across conditions,
11 but this table suggests that it is not.
12 MR. PARK: Yeah, and, again, I think this points
13 out the complexity, particularly with like inpatient
14 payment, because, one, states may have made specific policy
15 decisions to pay higher for one service or lower for
16 another. And so instead of using a standard DRG weighting
17 system, they've tweaked it a little bit so that -- you
18 know, like I said, states want to discourage the use of
19 early elective cesarean sections, and so they're going to
20 pay that closer to vaginal delivery as a policy choice to
21 try to discourage that. So there's one case where, you
22 know, the payment for a level of three different services

1 may be different. The other is, you know, as we showed,
2 the range of payment across hospitals may vary within the
3 state because of the way they make the payment, if it's
4 cost-based or per diem or average per stay or anything like
5 that, you know, that gets into, okay, what is the exact mix
6 of hospitals, you know, within that state for that
7 particular time period that you're analyzing. And, you
8 know, if you like looked at, you know, for whatever reason
9 that year, the fee-for-service data that we had had like a
10 very high mix of hospitals that were paid on a cost basis,
11 then that might make that state look -- you know, depending
12 on what services those particular hospitals provided, that
13 might make their average payment for those services higher
14 than what you see for others.
15 COMMISSIONER BURWELL: Okay. I'd just like to
16 echo what everybody else is saying. This is an extremely
17 fruitful path of analysis and what's missing seems to be --
18 is improved data. I'm a little concerned that the data are
19 2010 MAX data. So I would just encourage trying to fill --
20 pursue this analysis and try to fill in where we can on
21 better data sources.
22 MR. PARK: Certainly. I think at this point, you

1 know, we could probably update this to 2012 because I think
2 most of the states have submitted 2012 data. But, again,
3 at this point we wanted to present the results first, and
4 then if you feel like we should update to a more recent
5 year, then we could do that.
6 CHAIR ROSENBAUM: Alan, we'll give you the last
7 question because we are well over time.
8 COMMISSIONER WEIL: So what I want to do is sort
9 of make a comment on the comments because I didn't have
10 much of a comment initially.
11 I want us to think about the limitations and sort
12 of have the humility to understand that no matter how much
13 we dig into a lot of these things, the limitations are
14 going to in some ways overshadow what's doable. And so I
15 want to think about what we can do and try to -- the
16 netting-out conversation led me to want to make this
17 comment.
18 I think the analysis is really interesting at the
19 aggregate level, the comment about, you know, are we over -
20 - is it more than Medicare. I think state base payment
21 rates are important state policy statements, and they are
22 worth knowing and describing, even if there's a lot of

1 supplemental payments, even if there's a lot of managed
2 care. I still think how states pay is important
3 information and what those levels are is important.
4 Anything beyond that is going to be very hard to
5 tease out what's happening inside the institution, what's
6 happening inside managed care, what's happen -- how do you
7 appropriately allocate to individual DRGs.
8 The one item I do think we have to really grapple
9 with is this -- really the policy question of netting out
10 provider contributions, because that changes the whole
11 scale of what the top-line finding is about whether -- you
12 know, what the aggregate sense of Medicaid payment rates
13 are.
14 And so I think that one is different, but a lot
15 of these others are nice to know, and believe me, I'd love
16 to know them, too. But I think ultimately we have to
17 acknowledge that no matter how much we try to go behind
18 this, the caveats are always going to be extensive, and so
19 we should focus on what are the things we need to
20 understand better to have the right top-line conclusion.
21 CHAIR ROSENBAUM: Thank you very much, Chris.
22 All right. We're going to move right into the

1 next presentation, DSH.

2 ### IMPLICATIONS OF ACA COVERAGE EXPANSIONS FOR

3 MEDICAID DSH POLICY

4 * MR. NELB: Okay. Thank you, Sara.

5 So I am going to continue our discussion of

6 hospital payments by sharing some of our latest work on

7 disproportionate share hospital payments with you today.

8 I am the one presenting, but I just want to

9 acknowledge the contributions of the team that helped pull

10 all this data together, including my colleagues, Kacey and

11 Madeline at MACPAC, and our contractors, Dobson DaVanzo and

12 KNG Health. It's a team effort to pull all this together.

13 Okay. So, today, I'm going to begin, as always,

14 with a brief background on Medicaid DSH payments and then

15 focus the time on sharing some of our preliminary findings

16 on the effects of the ACA on hospital uncompensated care.

17 I will then look at how these changes in

18 uncompensated care relate to pending DSH allotment

19 reductions, and then discuss the implications of these

20 findings for the targeting of Medicaid DSH payments at the

21 state and provider level.

22 Overall, we're finding that ACA coverage

1 expansions are having very different effects in states that
2 have expanded Medicaid and those that haven't, which raises
3 a variety of policy questions for the Commission to
4 consider about whether and how state Medicaid expansion
5 decisions should affect the targeting of DSH payments.
6 So, for a quick refresher on Medicaid DSH, in
7 2014 states made a total of $18 billion in Medicaid DSH
8 payments to about half of all U.S. hospitals, which helps
9 offset those hospitals' costs of uncompensated care for
10 both Medicaid patients and the uninsured.
11 States have considerable flexibility to determine
12 which hospitals in their state receive DSH payments, but
13 they're statutorily required to make DSH payments to
14 hospitals that serve a high share of Medicaid and low-
15 income payments, which are known as deemed DSH hospitals,
16 and they're about 10 to 15 percent of all U.S. hospitals.
17 In addition, total DSH payments are limited by
18 federal DSH allotments, which are currently scheduled to be
19 reduced in fiscal year 2018, which begins in September of
20 next year. The amount of the reductions begins at $2
21 billion, a 16 percent reduction in 2018, and then will
22 increase each year up to 2025, when there's an $8 billion

1 reduction, which is about a 55 percent cut.

2 As background, I also just want to point out that
3 Medicare also makes DSH payments to hospitals, which have
4 the same name and acronym but are based on a totally
5 different formula. In 2014, the ACA changed the way that
6 Medicare DSH payments were calculated and in particular
7 created a new Medicare uncompensated care pool that is tied
8 to the number of uninsured nationally.

9 Although Medicaid DSH cuts have been delayed,
10 Medicare DSH cuts did take effect, as scheduled under the
11 ACA, and so far, Medicare DSH payments have been reduced by
12 about $3 billion.

13 As part of one of the pieces of legislation that
14 delayed the Medicaid DSH cuts, Congress required MACPAC to
15 report annually on Medicaid DSH payments and their
16 relationship to a variety of factors listed here.

17 MACPAC's first DSH report was published in
18 February of this year, and next year, these data will be
19 included in the Commission's March report to Congress.

20 In our first report, we primarily examined
21 hospital uncompensated care in 2013 using some of the data
22 that was available at the time. However, now new data are

1 available about the effects of the ACA on hospital
2 uncompensated care.
3 To preview some of the new data that are
4 available, this slide summarizes some of our preliminary
5 findings about the effects of the ACA on uncompensated
6 care.
7 Between 2013 and 2014, we found that hospital
8 uncompensated care fell by about $4.9 billion in states
9 that have expanded Medicaid. Although there was some
10 increase in Medicaid shortfall, it was offset by larger
11 declines in both charity care and bad debt. However, in
12 states that have not expanded Medicaid, we're not seeing
13 similar improvements. In hospital uncompensated care,
14 there was actually a slight increase.
15 Finally, although this decline in uncompensated
16 care has improved hospital margins by about 1 percentage
17 point between 2013 and 2014, we're finding that the deemed
18 DSH hospitals, those that serve the highest share of
19 Medicaid and low-income patients, are still reporting large
20 and negative operating margins in both expansion and non-
21 expansion states.
22 This figure compares the percent decline in the

1 number of uninsured and the decline in uncompensated care
2 as a share of operating cost for hospitals in both
3 expansion and non-expansion states. So, in this figure,
4 larger bars indicate a larger decline between 2013 and
5 2014.
6 In Medicaid expansion states, we found that there
7 was a larger decline -- there was a large decline in the
8 number of uninsured that was accompanied by an even larger
9 decline in uncompensated care. However, in non-expansion
10 states, even though there was some decline in the number
11 uninsured, it didn't seem to be accompanied by a similar
12 decline in uncompensated care for the uninsured.
13 Using some of this new uncompensated care data,
14 we developed a model to project hospital uncompensated care
15 costs in relation to pending DSH allotment reductions,
16 since DSH reductions are premised in part on the assumption
17 that ACA coverage expansions would reduce hospital
18 uncompensated care.
19 Our preliminary estimates, which I want to
20 emphasize are still preliminary, suggest that when the full
21 Medicaid DSH allotment reduction take effect in 2025,
22 hospital uncompensated care will be about $21.7 billion

1 lower than it would have been without the ACA.

2 This figure displays some of the preliminary

3 findings from our model for all hospitals at the national

4 level. The dark blue line in the middle shows projected

5 charity care and bad debt costs for the uninsured, and the

6 light blue line on top shows our projections for total

7 uncompensated care as defined for Medicaid DSH purposes,

8 which includes Medicaid shortfall.

9 The bar at the bottom of the chart show Medicaid

10 DSH allotments, with the solid bars showing federal DSH

11 funds and the hollow bars on top showing the state's share

12 of Medicaid DSH funding. We're showing the status quo

13 scenario with federal DSH allotment reductions beginning in

14 2018 and increasing each year until 2025.

15 Overall, we see that uncompensated care is

16 expected to continue to fall as ACA coverage expansions

17 take full effect, but Medicaid DSH funding is still

18 projected to be less than total hospital uncompensated care

19 in the aggregate.

20 In your materials, we have some additional

21 information about our projections of uncompensated care for

22 expansion and non-expansion states. As I discussed

1 earlier, virtually all of the reductions in uncompensated
2 care is occurring in expansion states, so these charts look
3 very different for the two subsets of states.
4 Our modeling raises several questions about how
5 DSH allotment reductions should be targeted at the state
6 level. Under the allotment reduction that CMS initially
7 proposed for DSH allotment reductions, Medicaid expansion
8 states are expected to have larger reductions than states
9 that have not expanded Medicaid, since the formula bases
10 one-third of the reductions on the number of uninsured in
11 the state, which is related to whether states expanded
12 Medicaid.
13 In your materials, we present some preliminary
14 analysis of the effects of changing the relative weights of
15 this formula in order to apply larger or smaller reductions
16 to states that have expanded Medicaid.
17 However, in order to evaluate any of these
18 options or others that the Commission would like to
19 consider, the Commission will need to think about the
20 question about whether and how state Medicaid expansion
21 decisions should affect state DSH allotments.
22 In addition to looking at targeting at the state

1 level, our analysis also has implications for the targeting
2 of DSH payments at the provider level. For example, the
3 Commission has previously discussed the possibility of
4 raising the minimum eligibility threshold for DSH payments
5 above the current level, which is a 1 percent Medicaid
6 utilization rate. However, as the Commission considers
7 what alternative thresholds might be appropriate, it's
8 important to be aware that states and hospitals that have
9 expanded Medicaid have higher Medicaid utilization rates.
10 Within states, however, we continue to find that
11 the deemed DSH hospitals serve a higher share of Medicaid
12 in low-income patients and also have higher levels of
13 uncompensated care when we look at levels relative to other
14 hospitals in the state.
15 In addition, there may be some measures, such as
16 the low-income utilization rate, which is based on both
17 Medicaid and uninsured patients and seems to be less
18 affected by state Medicaid expansion decisions.
19 This final chart just illustrates, again, the
20 differences in uncompensated care that we're seeing between
21 expansion and non-expansion states in 2014. We found that,
22 rather surprisingly, DSH hospitals in Medicaid expansion

1 states now have less uncompensated care than non-DSH
2 hospitals in states that have not expanded Medicaid.
3 However, within each state, again, these deemed DSH
4 hospitals, the one that served the highest share of
5 Medicaid and low-income patients, have more uncompensated
6 care than others in their state.
7 That concludes my presentation today. Here are
8 some policy questions you may want to consider, and I'm
9 happy to answer any questions that you might have, but
10 mostly, I'll try to be a good listener and incorporate your
11 feedback into our future work on this issue.
12 Thanks.
13 CHAIR ROSENBAUM: So, Sheldon, would you like to
14 lead us off again?
15 COMMISSIONER RETCHIN: Yeah. Thanks. This is
16 kind of my morning.
17 So this is great work, and I continue to think
18 that the analysis on the supplemental payments,
19 specifically to DSH, has important contributions and is
20 important policy as we make our way towards October and
21 some major policy implications with the reductions in DSH.
22 As I read it, it sort of confirmed what I had

1 thought, and it's that the expansion states and the non-
2 expansion states from the get-go were and are very
3 different, just in terms of the DNA, the way that they
4 funded the vulnerable populations in Medicaid and the
5 number of those individuals in those states. Those states
6 just happen to be different, and the hospitals within are
7 different.
8 As I read it as well, post-expansion, it struck
9 me that those hospitals that are deemed DSH hospitals or
10 those hospitals that were reliant on supplemental income
11 before expansion continued to be reliant, with the
12 expansion, they would say, "We are getting better and
13 feeling worse."
14 There are only so many conclusions you can make
15 after this. Why are these hospitals still struggling
16 financially? And I do want to get back to one table on
17 that.
18 I am sure there are other explanations, but one
19 is that the supplemental income, in this case, DSH, is
20 being used in some of those states or many of those states
21 in a different way than we might suggest, and that's why we
22 continue to focus on targeting. That seems like a very

1 reasonable and, I think, easily validated concern.

2 There could be a moral hazard that with

3 expansion, some of these hospitals have been flooded with

4 patients who are Medicaid and altered the payer mix in

5 those hospitals that are deemed DSH hospitals or those

6 hospitals that happen to take care of these patients,

7 because, let's face it, when it comes to government-

8 sponsored care, Medicare and Medicaid, hospitals that make

9 margins in those payers have negative overall margins; that

10 is, almost all hospitals still cost-shift in using

11 commercial payers. Those that don't aren't making money

12 overall.

13 Or is it that these hospitals are just

14 inefficient and ineffective, they don't have the

15 infrastructure from before, or is there a difference in

16 beneficiaries? I continue to go back that it's in the way

17 DSH is being used and would like to propose that in some

18 way or another, the Commission makes specific or explicit

19 recommendations on the allocation of DSH with an allocation

20 of DSH cuts.

21 Before I pass this along, I just wanted to go

22 back to one table, Rob, which is Figure 9 on page 19. I am

1 still bothered by the last column that hospitals -- these
2 are safety net hospitals, we're all familiar with, who have
3 a negative operating margin of almost 6 percent. After
4 DSH, still have a negative margin of 2.8, 3 percent, but
5 somehow, after that, from other income are able to bounce
6 up to 6.3 percent. It just doesn't ring true for me. It
7 can't be from earnings off of their balance sheets. It
8 just can't be. And maybe local communities are
9 supplementing these hospitals, but to the tune of a 6.3
10 percent total margin just doesn't ring true.
11 CHAIR ROSENBAUM: Okay. Stacey.
12 COMMISSIONER LAMPKIN: So thanks, a lot of great
13 stuff here.
14 I read this, and I feel like we need a theory of
15 everything, and I want to explain. Really, I do think we
16 need a theory of everything. It feels like we're being
17 asked for nothing less than what is the role and purpose of
18 DSH in the new world, and that's the question here. And
19 then it doesn't take much to think, well, I need to
20 understand how to think about adequate Medicaid payments
21 and where does Medicaid shortfall belong and what is the
22 right mechanisms to pay hospitals adequately for the

1 services provided to Medicaid recipients, and should that
2 have anything to do with DSH? And so I really feel like I
3 am reaching to tie several of these linked things that
4 we'll talk about today together before we can really know
5 where to go specifically on DSH allocations, which feel so
6 -- not mundane, but technical in light of the broader
7 question. So that's kind of where I get stumped on here.
8 I'll just make a couple of specific comments
9 about the material you've presented as well. I think that
10 the explanation of the interaction between the Medicaid
11 shortfall and uncompensated care and expansion states and
12 non-expansion states was enormously helpful, and that's
13 great information for people to understand how that works
14 and how that works together.
15 The projections and the graphs you put together
16 on the projections, outstanding, intuitive way to
17 understand the information presented.
18 I, too, struggled with the operating margins in
19 the quartile exhibits. I either need different graphics or
20 help in the narrative understanding what the operating
21 margins mean and how I'm supposed to relate them to the DSH
22 questions and what conclusions to draw. So I think that

1 area could use a little bit, but very helpful information.
2 Thank you.
3 CHAIR ROSENBAUM: Alan.
4 COMMISSIONER WEIL: So I'm once again with
5 Stacey. I think you need theory of everything.
6 What I liked about this is it gave me the
7 opportunity to pretend I'm a member of the Supreme Court
8 writing NFIB v. Sebelius, because, in essence, what you're
9 asking -- I mean, the question that's been presented is,
10 How do you handle a slice this big in a context that is not
11 the one that the people who wrote it thought it was going
12 to be? So I took a cut at it, and we'll see if it's of any
13 interest to anyone else.
14 So I start with DSH was designed to provide
15 hospitals with money, and like many other things in
16 Medicaid, states have a lot of flexibility under the
17 statute in how they define and distribute, other than the
18 basic standards that you've mentioned.
19 And I also -- maybe, Sara, you and I have been
20 talking too much over the years, but I always want to
21 remind people, DSH is a Medicaid expenditure made by the
22 state and by the federal government. It's not different.

1 So here, we have the Affordable Care Act that
2 reduces DSH payments based on what happily turned out to be
3 the accurate assumption that when you expand Medicaid
4 uncompensated care, it does down, which that might not have
5 turned out to be so, but now we have really -- this is not
6 the first. We've published in "Health Affairs." Also,
7 it's very clear.
8 The question you asked that I focused on, because
9 it's the one that I think is most -- the one that I can get
10 my head around best is this question of should you treat
11 states that expanded differently than those that you don't,
12 and this is my way of thinking about it, for what it's
13 worth. states' decision whether or not to expand Medicaid,
14 although we didn't think it was going to be a choice, is
15 now a choice, but it's one among many that states have the
16 authority to make in Medicaid. And, particularly, another
17 one that states get to make is what are their base hospital
18 rates, and the notion that we would sort of penalize -- and
19 I know you didn't use that word, but that's how a lot of
20 people talk about it -- penalize states for their choice on
21 the Medicaid expansion, but we never in DSH think about
22 penalizing states for having low hospital payment rates,

1 which creates a similar problem, that seems like an odd
2 match to me.
3 Similarly, the politics and perception of how
4 real the state's share of DSH is, that's part of a bigger
5 issue that we're going to talk about more, but I think
6 that's a red herring because, once again, it would be
7 putting DSH in a different category than all the broader
8 questions about Medicaid, which I think is Stacey's point,
9 which is that to pull this out separately is a challenge.
10 And that then gets me to sort of the governance
11 problem, which is this is a program that provides resources
12 to hospitals to help them serve people, and while obviously
13 hospitals and people are in states and may lobby and
14 advocate for certain positions about Medicaid expansion, at
15 the end of the day, the decision-maker about Medicaid
16 expansion is the state government and not the hospitals or
17 the people they serve, and so to hold the hospitals or the
18 people they serve accountable or penalize them for that
19 decision also doesn't make sense to me.
20 So where I land is that while I think the merits
21 of the size of the DSH cuts in the ACA are certainly open
22 to question, given that not all states expand to Medicaid

1 and those cuts were based on that assumption, if we're
2 going to focus solely on the question of the distribution
3 of DSH dollars across states in the wake of this unexpected
4 choice by states, I would stick to all of the same factors
5 that we should be thinking about in DSH allocation, even
6 without this provision, and not sort of carve out state
7 Medicaid expansion decision as different from all the other
8 state choices.
9 So I think there is a lot of merit in asking the
10 question how should states allocate DSH dollars. How
11 should they be matched? Should there be federal
12 allocations to hospitals that go around states? I think
13 those are all interesting and important questions, but if
14 we're presented with sort of the -- it's not really very
15 narrow, but if we're presented with a specific question of
16 whether state allocation should be varied based on the
17 state Medicaid expansion decision, even though I have views
18 about what I would hope states would do, based on what DSH
19 is designed to do and based on what Congress said about DSH
20 or what we understand Congress' thinking, which is always a
21 somewhat risky endeavor in the cuts and the ACA, I'd have a
22 hard time putting that in there.

1 And then I would just -- since that was all
2 focused on your one question and you asked others, I would
3 align myself with both the high quality of the work and a
4 few areas where I think there's additional clarification.
5 CHAIR ROSENBAUM: I have to say, which has been
6 the issue on my mind all morning, that given the tools in
7 the state agency's toolbox for steering around all kinds
8 of, you know, Scylla and Charybdis situations, whether the
9 Medicaid expansion decision ought to be viewed in isolation
10 is really -- rises to me as a very important one. You
11 know, there are just so many ways in which a state can
12 counterbalance one set of decisions with another,
13 particular where hospital payment is concerned.
14 I know you have to step out, and did you have a
15 comment?
16 COMMISSIONER COHEN: Well, just to quickly say I
17 agree with both Alan's analysis and his conclusion, and I
18 just think that we really -- we should focus the question
19 I mean, with some agreement, that better targeting of DSH
20 as a possible area for our, you know, making a
21 recommendation or taking some future action where, sort of,
22 redesigning all Medicaid payment in the short term, by

1 December, probably not so much.

2 I would just say we need to focus on the purposes
3 of DSH, which we've written about. It's about, you know,
4 access to human beings and the financial stability of
5 safety net hospitals, which we really don't have much of a
6 definition of but we could help to generate one, and I do
7 really think we have to be looking at what the situation of
8 the specific hospitals is in terms of their -- the amount
9 of uncompensated care that they're providing.

10 Now that only answers one question, which is the
11 question that Alan also answered, the question of exactly
12 what the, like -- what the targeting mechanism is is really
13 complicated, and I would just say I think we do need -- so
14 deemed DSH hospitals is like, it's exists. It's a standard
15 that exists already but we don't really know anything about
16 the distribution of hospitals around that standard. We
17 know how many hospitals are in the deemed DSH -- you know,
18 like heavy, intense DSH hospitals -- but we don't know
19 whether there's a bunch that are right outside, or what the
20 component, sort of, parts of it are.

21 So I think a little bit more analysis around sort
22 of distribution under a number of different standards would

1 be very helpful and us, sort of -- if we decide to go down
2 this path, targeting the actual sort of hospital standards
3 that we want to use.
4 CHAIR ROSENBAUM: Toby, did you want to jump in?
5 COMMISSIONER DOUGLAS: No. I'm okay.
6 CHAIR ROSENBAUM: Let me see if we have a --
7 COMMISSIONER GORTON: So I would just build on
8 this theory of everything question, because I do think it's
9 important. And I guess the way I think about it is each of
10 the state health care delivery systems has a financial
11 ecology, and the federal government contributes a big slide
12 of what goes into that, state governments, and then the
13 employers and the commercial insurers, as well, and then in
14 states with heavy military presence you've got TRICARE and
15 -- I guess you'd call it -- that's federal but it's DoD so
16 it's different.
17 For me, the question -- the important question is
18 are those federal dollars being fairly and equitably
19 distributed across the state markets? And I think we have
20 some evidence that maybe they're not, and I think we have
21 some evidence that some states have been better at drawing
22 down those federal dollars than others. And I think that's

1 a relevant place to shine some light.
2 Now, some states have made, to Alan's point, a
3 political, philosophical, and some of them frame it as a
4 moral choice not to drive down federal dollars. So that's
5 how Governor Jindal framed his non-participation in the
6 Medicaid expansion. And whether or not I agree with that,
7 we need to respect the state's opportunity to do those
8 things.
9 So I guess for me the other big question here is
10 the federalism question. I think we ought to be interested
11 in whether or not federal funds for health care are being
12 equitably distributed across states, and I think MACPAC has
13 a role to play in looking at the Medicaid slices of that,
14 and within Medicaid DSH, and, you know, you could throw in
15 DSRIP and some of the other supplementals that go on.
16 But I don't think we should kid ourselves that
17 Medicaid is necessarily the whole pie, and I don't think we
18 should kid ourselves that at the federal level we have
19 enough granularity of understanding of these individual
20 state health care delivery systems to be able to do the
21 allocation within the state programs. And we talked about
22 it -- I won't rehearse it again. States have made a lot of

1 choices, and some of them are thoughtful and some of them
2 are less thoughtful, and some of them we agree with and
3 some of them are thoughtful and we still disagree with
4 them. But they've made them. And I worry about us taking
5 a very narrow sliver, which is DSH, and starting to pull on
6 that thread without thinking about what unravels across the
7 whole delivery system.

8 So as a health plan who negotiates with both the
9 state customers and with the provider community, we do a
10 lot of horse-trading. And so there's -- somebody was
11 talking about cost-shifting and the cost-shifting is a big
12 deal. Some of the state policy decisions are exclusively
13 made with an eye towards that cost-shifting. And so I do
14 think we need to worry about federalizing this and moving
15 the governance of this to the federal level.

16 So I would be inclined to say we ought to figure
17 out -- my point of view would be that MACPAC should think
18 about making recommendations about equitable distribution
19 of Medicaid funds, including DSH, but at the end of the day
20 that the states should decide how they allocate it, because
21 they have more insight into how their mental health and
22 foster systems and all the other things work than at the

1 federal level.

2 CHAIR ROSENBAUM: Well, and I would note that to
3 the extent that we think about the question of what is
4 equitable in the distribution of Medicaid funds we will see
5 this afternoon that the loop sort of gets closed because
6 then you have the question of what is equitable policy on
7 where states -- the flexibility states should have to
8 develop their expenditure policies.

9 And so this is where we've now, you know, sort of
10 managed to attach all of the sessions into one bolus.

11 COMMISSIONER RETCHIN: You know, I'll just weigh
12 back in on the -- and I realize DSH is a relatively small
13 part of -- which was another part of the analysis, was
14 illuminating.

15 I'll first of all call attention, on Figure 2,
16 page 7, that the Medicaid payment-to-cost ratio estimates
17 from differing methods have some variation. I do point out
18 that regardless -- even if you took the AHA or the DSH
19 audits, that if you have a growth in that segment of a
20 provider's population, you're still dealing with 10 percent
21 losses on this population.

22 But going back to Kit's point, there are states

1 that actually abdicate from the responsibility of
2 allocating DSH. They abdicate it or transfer it to a third
3 party, hospital associations, where the policies really are
4 not reflected in terms of the population being served but
5 rather than of the members.

6 And I also think that a policy that says that
7 hospitals are eligible for DSH if they have 1 percent
8 utilization rates, surely this will be corrected or amended
9 in some way or another. But I would like to see us weigh
10 in. We have data here. It's a relatively small amount
11 that's being distributed but still it's folding money, and
12 that maybe we could start to focus on that as a target.

13 CHAIR ROSENBAUM: Any other questions for Rob?

14 [No response.]

15 CHAIR ROSENBAUM: Seeing none, thank you so much.
16 It was terrific.

17 And we now have time for public comment on the
18 first two segments of this morning.

19 Thank you so much. If you could just identify
20 yourself.

21 **### PUBLIC COMMENT**

22 * MS. GONTSCHAROW: Hi. Good morning. Zina

1 Gontscharow with America's Essential Hospitals. Thank you
2 very much for the opportunity to comment and for your
3 continued focus on the issue of Medicaid DSH. We also
4 thank you for your continued hard work on the annual DSH
5 payment study and we are looking forward to its release.
6 Medicaid DSH is absolutely vital to Essential
7 Hospitals across the country. Because of our commitment to
8 care for the underserved, half of our patients are
9 uninsured or Medicaid beneficiaries. Essentials Hospitals
10 had an aggregate zero percent operating margin in 2014,
11 following several years of negative margins. Without
12 Medicaid DSH, their margins would have been an
13 unsustainable, negative 6.21 percent.
14 As such, Essential Hospitals must have the
15 financial resources they need to keep their doors open and
16 provide services to all patients, particularly low-income
17 and other vulnerable people. This is consistent with
18 Congress' stated intent in the DSH statute.
19 As we look forward to the methodology for the
20 impending DSH cuts, we urge better targeting to the
21 hospitals that are truly serving the underserved, the
22 uninsured, and the Medicaid beneficiaries.

1 We look forward to any opportunity to work with
2 the Commission on this important topic.
3 Thank you.
4 CHAIR ROSENBAUM: Thank you.
5 Any other comments?
6 [No response.]
7 CHAIR ROSENBAUM: Yeah. Why don't we take a
8 break and resume in about 10 minutes.
9 * [Recess.]
10 CHAIR ROSENBAUM: Why don't we reconvene in the
11 next couple of minutes?
12 [Pause.]
13 CHAIR ROSENBAUM: All right. So we are back, and
14 Kristal Vardaman is going to take us through the role of
15 residential care settings in long-term services and
16 supports.
17 **### ROLE OF RESIDENTIAL CARE SETTINGS IN DELIVERING**
18 **LONG-TERM SERVICES AND SUPPORTS**
19 * MS. VARDAMAN: Great. Good morning,
20 Commissioners. Again, I will be presenting on the role of
21 residential care settings in serving Medicaid
22 beneficiaries, and for the order of today's presentation,

1 I'm going to begin with some background on home and
2 community-based services in residential care settings.
3 I'll then go on to some findings from some work that RTI
4 conducted for the Commission and then discuss some future
5 work and potential policy questions for your discussion.
6 To start, home and community-based services have
7 been promoted in recent years by states and the federal
8 government through a variety of investments. Home and
9 community-based services include services where providers
10 come to a beneficiary's home, like personal care attendants
11 that may help with activities of daily living. It also
12 includes providers where the beneficiary is traveling to
13 them, like day service providers. And it also includes
14 residential care settings, which we'll discuss today, that
15 integrate housing and care.
16 In fiscal year 2013, for the first time national
17 Medicaid expenditures on home and community-based services
18 exceeded institutional care, and based on more current data
19 for 2014, that trend continued into 2014.
20 Residential care settings are community-based
21 settings for individuals who cannot live completely
22 independently. They have a variety of different

1 definitions and licensing by different states. It includes
2 both small group homes as well as large assisted living
3 communities. In addition to the size, residential care
4 settings vary in the types of services they provide and the
5 populations they serve. The most common services provided
6 are personal care services. Fewer offer skilled nursing
7 care. And also some focus on specific populations such as
8 individuals with dementia.
9 Despite the progress that states and the federal
10 government have had in rebalancing, there's current
11 policies that provide some incentives for
12 institutionalization rather than community settings, even
13 when beneficiaries might be well served in a residential
14 care setting. Some of these incentives include the fact
15 that HCBS are optional while nursing facility services are
16 a mandatory benefit. And as you know, states administer
17 HCBS through waivers often which may have waiting lists
18 which limit access to settings such as residential care
19 settings.
20 Also, Medicaid pays for room and board at
21 institutions but not for residential care settings or
22 private homes, which is another disincentive for

1 residential care settings.

2 As we began this work, we found that there were
3 few studies that focused on residential care settings and
4 how they serve Medicaid beneficiaries. And also there are
5 a number of policy changes in the long-term services and
6 supports landscape that may affect a beneficiary's access.
7 So those were some motivations behind pursuing this work.

8 In addition, as we began pursuing this work, we
9 found out that GAO had received a related request, and so
10 there's some congressional interest in this as well.

11 I'd like to thank RTI International for their
12 work and doing this for us. Their work involved three
13 different tasks, which I'll go through today. First, they
14 developed a compendium of Medicaid coverage and payment
15 policies for all 50 states and the District of Columbia.
16 Second, they conducted interviews with subject matter
17 experts about policies that may affect beneficiaries'
18 access to residential care settings. And finally, they
19 conducted case studies of four states -- Colorado, Florida,
20 North Carolina, and Washington. For those case studies,
21 they did some more in-depth reviews of those states'
22 coverage and payment policies as well as spoke with

1 stakeholders including state Medicaid staff, providers, and
2 beneficiary advocates to get their perspectives on some of
3 the policies that may influence access.
4 First I'll walk through some of the findings on
5 the next few slides related to the compendium and their
6 descriptions of Medicaid coverage and payment policies.
7 First, states can use several Medicaid
8 authorities to cover services in residential care settings.
9 Some of these are described in detail in the appendices in
10 your briefing materials. They can use both waiver
11 authorities as well as state plan authorities, and states
12 may use different authorities in order to target
13 residential care setting coverage to specific populations.
14 Also in the appendices in your materials is a
15 large table that describes states -- authorities the states
16 use to cover services in residential care settings as well
17 as the related payment methodologies that they use. And so
18 what RTI found was that state payment rates vary
19 considerably across -- from one another as well as compared
20 to the private pay rates in that state. So there are some
21 numbers in your materials. It's also important to note
22 that those private pay rates do include room and board,

1 which the Medicaid rates do not.

2 RTI also looked at what kinds of policies states

3 may use to make room and board more affordable since they

4 cannot use Medicaid funds to pay for room and board in

5 community settings. Some states through the Supplemental

6 Security Income system have provided additional payments to

7 beneficiaries who reside in residential care settings to

8 allow them to afford room and board. Other states limit

9 what residential care settings can charge for room and

10 board, either by setting a cap or by setting a combined

11 rate from which the state is paying for the service portion

12 and beneficiaries continue to pay for their room and board.

13 Some states also allow family members to supplement room

14 and board costs.

15 The next few slides describe some of the results

16 from the focus groups and stakeholder interviews.

17 First, in terms of payment rates, stakeholders

18 said that low payment rates compared to the private pay

19 rates discourage participation of residential care settings

20 in Medicaid, and that small residential care settings are

21 most affected because they cannot use private payments to

22 subsidize Medicaid payments. And some of the strategies

1 that stakeholders said that providers use in response to
2 this is: first, financial screening of applicants and
3 ensuring that an applicant can pay privately for a certain
4 amount of time before they are likely to spend down to
5 Medicaid eligibility; or discharging residents once they
6 have spent down to Medicaid eligibility.
7 Next, stakeholders were asked a variety of
8 questions about the effects of the home and community-based
9 services settings rule and its implementation. This rule
10 defines the requirements for home and community-based
11 service providers, and these requirements are aimed to
12 encourage beneficiary independence as well as to promote
13 community integration.
14 As a part of this process, states are currently
15 reviewing home and community-based services settings. They
16 are identifying settings that will be subject to what is
17 called "heightened scrutiny" from the Centers for Medicare
18 & Medicaid Services.
19 And stakeholders were concerned about small and
20 rural providers mostly and those that are co-located with
21 nursing facilities and how they are going to be able to
22 adapt to the rules requirements, particularly around things

1 like community integration and giving beneficiaries
2 opportunities to engage in community activities, whether
3 that would be an issue for smaller or rural facilities, and
4 those that are collocated with nursing facilities was
5 another concern.
6 We also heard from other stakeholders that
7 there's concern around dementia care units which may have
8 elements that are aimed to in some ways restrict or monitor
9 beneficiaries movements to prevent wandering.
10 Another issue that stakeholders were asked about
11 was the adoption of managed long-term services and
12 supports, which is something that continues to increase
13 among states. And there really wasn't a lot of experience
14 or understanding of what the effects on access would be.
15 Some of the things we heard is that contracting may be a
16 challenge, and based on some of our past site visits to
17 states with managed long-term services and supports, we
18 know that some HCBS providers that don't have a lot of
19 experience contracting with managed care, this is a broad
20 challenge that would also apply to residential care
21 settings.
22 In addition, care coordination issues may arise

1 in terms of how are plans going to interact with their care
2 coordination system, with whoever is coordinating the care
3 at the residential care setting. These are unknowns that
4 we didn't get a clear answer from in our case studies.
5 In terms of other issues, some other things that
6 came up were the fact that the Money Follows the Person
7 demonstration, which does not allow funds to be used to
8 transition beneficiaries with more than four residents, and
9 that was a limitation in terms of where beneficiaries who
10 are trying to get out of a nursing home or other
11 institution where they can go with Money Follows the Person
12 support. Also, current CMS policy does not allow for
13 retroactive payment for residential care settings when
14 eligibility determination is delayed, and some of the
15 states and stakeholders told us that that is, you know,
16 common. And there is some retroactive payment for
17 institutional settings, so there's a discrepancy there.
18 In terms of future work, we have some ongoing
19 work that is relevant to residential care settings, so I
20 just wanted to make you aware of that. We're currently
21 just beginning to look at doing some analysis of home and
22 community-based services claims data and try to describe

1 with more granularity what's being spent on different types
2 of HCBS providers. And hopefully we'll have some results
3 to share that will also have some descriptions on what's
4 being spent specifically on residential care settings.
5 We also have some ongoing work now with Health
6 Management Associates. They are reviewing state contracts
7 with managed care plans and states with MLTSS, and they are
8 looking for network adequacy provisions that are contained
9 in those state contracts. The final managed care rule did
10 instruct states to develop network adequacy provisions, and
11 so we're looking to see what currently exists and where
12 states may need to develop some more network adequacy
13 requirements, and so hopefully we'll identify some that are
14 relevant to residential care settings in that work.
15 We're also interested in the discussion in
16 hearing if the Commission is interested in additional work
17 in this area. I'll set up in the next slide a few policy
18 questions that might get the discussion started.
19 So, first, as I noted, the effects of the home
20 and community-based services settings rule may or may not
21 affect availability where it's uncertain right now, but we
22 could do some more analysis in that area. We could also do

1 some more analysis about how MLTSS adoption may affect
2 residential care settings.
3 And, finally, the last question is: Should
4 Medicaid policy promote the use of these settings, either
5 by removing barriers that may currently exist or by
6 promoting policies such as those that make room and board
7 more affordable?
8 So I'm looking forward to hearing your discussion
9 and looking forward to direction on where we might go in
10 this area. Thank you.
11 CHAIR ROSENBAUM: Comments?
12 COMMISSIONER BURWELL: So I think this is a great
13 first cut at kind of the issue of the role of residential
14 care settings in the new world of LTSS where an increasing
15 majority of people are being served in non-institutional
16 settings outside of nursing homes.
17 I see there are lots of opportunities for future
18 work in this area, and I think in order to make a policy
19 contribution in this area, we have to kind of narrow our
20 focus. There are a number of important issues related to
21 the role of housing in community-based LTSS that we may
22 want to tackle, and each of them is a pretty large issue in

1 itself. I don't think we can -- I would not support, you
2 know, kind of a broad analytical approach to residential
3 care facilities. It's just -- you know, there's different
4 populations, a huge variety of residential models that are
5 being used, and so I would like our conversation to kind of
6 hone in on things.
7 I'll just mention a few, and Kristal has brought
8 this up. A big one is the settings rule, and where states
9 are going and CMS is going with the settings rule. I don't
10 think people really understand what the settings rule is
11 all about. The settings rule is basically a realization
12 that the definition of an institution is very -- is not
13 just related to the physical, you know, structure where
14 someone is living, but to the kind of life they live
15 wherever they are. So the settings rule wants to define
16 community-based services more in terms of the ability of
17 the individual to live independently. A big one is, you
18 know, for example, does a person have control over his or
19 her front door in terms of who comes into their residential
20 setting and who doesn't? I mean, that's a pretty big deal.
21 So those kinds of things.
22 And also the recognition that even though we've

1 been "successful" in shifting and this supposedly
2 rebalancing thing, there are a lot of people living in
3 community-based settings that are not living the kind of
4 life that we would want to promote from a policy
5 perspective. So there's a lot of work around that. States
6 have -- a lot of their residential care settings are not in
7 compliance with the rules. They have to come into
8 compliance. There's a lot of work that we could do just in
9 terms of monitoring and seeing where that is.
10 Some of the states have already come in with
11 their compliance reports. I think we should be reviewing
12 those reports as they come in. They will raise a lot of
13 issues, et cetera. That's one.
14 I think MLTSS is a big component of this.
15 There's no doubt that one of the reasons a lot of states
16 are shifting to MLTSS models is that they think a private
17 sector approach to the development of alternative
18 residential care settings is superior to their own attempt
19 to expand housing opportunities for people living in the
20 community. And I think there's some -- there are
21 definitely best practices out there in terms of what some
22 managed care companies have done in developing residential

1 models for their members.

2 Another obviously important piece of this is that
3 MLTSS creates a financial incentive for managed care
4 contractors to find and develop alternative residential
5 care models for their members because it's to their
6 financial advantage to do so. So kind of the intersection
7 of MLTSS and housing development is a big one.

8 The third is rather than, you know, is there an
9 institutional bias because of this, there is a conversation
10 going on within CMS right now around what are the limits of
11 Medicaid coverage related to housing services. So there's
12 a fairly strict line drawn, Medicaid does not pay for room
13 and board, and that line is pretty strongly drawn. But
14 there's a whole set of services around supporting people in
15 housing. Does Medicaid cover services related to finding
16 housing options for people, housing coordinators, whatever,
17 people whose job it is to expand housing? Can Medicaid
18 cover people to support tenancy in housing, helping
19 negotiate leases, supporting people with disabilities to
20 understand the importance of their relationship with
21 landlords and to not break the lease so that they don't
22 lose their housing? All kinds of housing-related services,

1 and without getting into the details, that has become a
2 fairly large area of conversation within CMS.
3 CHAIR ROSENBAUM: With a public document, as I
4 recall. There is, I think, a public policy on this
5 question.
6 COMMISSIONER BURWELL: There was an informational
7 bulletin put out. The OGC, after it came out, felt like it
8 went too -- had some reservations about it. They've gotten
9 more involved. So there's a fairly large issue, and even
10 though Medicaid doesn't pay room and board, to what extent
11 can Medicaid support people finding and living in
12 alternative settings?
13 I'll stop there. There's a lot of other issues.
14 I just want to say that in most countries, housing and
15 services are delinked. So the United States is not -- is
16 different in the fact that it often covers an institutional
17 setting -- I mean, a bundled payment for the whole thing.
18 Obviously -- I mean, when you delink housing from services
19 for long-term-care populations, you have to have some kind
20 of financing mechanism or -- you know, for people to find
21 housing. So it's related to what other social programs are
22 out there to support people with their room and board

1 costs. So that's an issue, kind of how the room and board
2 component is financed in this new world of community-based
3 settings is kind of going to be an ongoing issue.
4 CHAIR ROSENBAUM: So I have just two follow-up
5 questions for you.
6 One, among these sort of strains that you've
7 pulled out for us, is there any suggestion or has there
8 ever been a suggestion of the federal government using any
9 of its piloting authority to test out discrete models? I
10 mean, for example, on number one, you noted that there are
11 many, many models and approaches to housing. And then this
12 whole question of managed long-term services and supports
13 and whether you might test out how that would work were
14 housing, in fact, to be on a more stable revenue stream.
15 So I'm just wondering whether there has been any piloting
16 work, any discussion of piloting work. That's number one.
17 And, number two, among the three sort of buckets
18 you created for the discussion, is there one place, given
19 your expertise in this area, that you'd like to see us
20 maybe prioritize? How would you prioritize your list?
21 COMMISSIONER BURWELL: I think I'd like to hear
22 other [off microphone].

1 CHAIR ROSENBAUM: Your mic.
2 COMMISSIONER BURWELL: My intellectual curiosity
3 in this area is quite broad, so I kind of don't want to be
4 forced into picking one at this point. There are a lot of
5 things we can work on, and we can make valuable -- I think
6 we can definitely add to the conversation about housing and
7 services and LTSS.
8 CHAIR ROSENBAUM: And on the piloting issue, has
9 there ever been an attempt to pilot around this question
10 and to, you know, design a pilot to test it out at all
11 under 1115?
12 COMMISSIONER BURWELL: Pilot, specific kinds of
13 residential care models --
14 CHAIR ROSENBAUM: Not nursing facilities.
15 COMMISSIONER BURWELL: I would say pretty much
16 no. I mean, I think there's a fair amount of -- I mean,
17 the other thing, I'll bring up one other issue, is that
18 obviously when you talk about housing, you're talking about
19 a whole different -- I mean, the availability of housing
20 for low-income people is related to the local market, and
21 markets change. You know, like, for example, in Arizona,
22 there was a huge overdevelopment of assisted living

1 facilities, and during the last recession, a lot of places
2 that initially were developed as private pay only all of a
3 sudden said, "Oh, yeah, we'll take Medicaid people." You
4 know, so that kind of housing market dynamic fits into the
5 policy discussion.
6 VICE CHAIR GOLD: Yeah. In some ways, Brian was
7 talking about getting narrower. I have some narrower ideas
8 but in a broader context. I found this was really
9 fascinating. I didn't know much about residential care and
10 Medicaid and I think this work really has helped move
11 things along.
12 I guess I start out -- I'm not sure that it makes
13 sense to look at residential care in Medicaid without
14 looking at the broad community and home-based services. I
15 mean, I sort of start out by saying, you know, Medicaid --
16 people in Medicaid, subject to their unique conditions and
17 all the rest, want the same access other people have to
18 services, and my impression is that -- and I think the data
19 support this -- that people, if they can, want to stay at
20 home, and they want to get the support they can. If they
21 can't, they want to go into something like these
22 residential facilities or independent living or whatever

1 other things exist, and if they have to, then they go to a
2 nursing home or something like that.
3 And so to work on the residential piece without
4 working on the people -- the supports to people to stay at
5 home, to me runs the risk of just extending the
6 institutional side. So the fact that there is waiting
7 lists in -- and gaps in supply of personal care services,
8 and adult day care, and things that people need, we can't
9 look at residential facilities without also looking at some
10 of those limits.
11 And we probably also should get to the question
12 of should -- as opposed to residential care -- and this was
13 in the paper, you know, where it's, at least on the nursing
14 facility side, it's a mandated benefit -- states have to
15 use waivers and they can put limits on home- and community-
16 based services. And should that be the right policy? I
17 know part of the concern, I think -- at least it was years
18 ago -- is that if you don't, everyone is going to use these
19 services and you're going to be supporting everyone. Well,
20 it would be very interesting to look at what we know about
21 that. Is it, in fact, true that if you cover these
22 benefits that people will come out of the woodwork and

1 you'll end up -- the cost would be enormous, or isn't it?
2 Or if it potentially true, are there offsetting policies
3 that could limit that, that would make it more affordable?
4 So, to me, some of that is an area for empirical
5 work. So I would tie what we do with residential care to
6 looking at the limitations in support for people at home,
7 and really do some targeting work on what I think -- and
8 correct me if I'm wrong -- but what I think is one of the
9 main barriers to further expanding the community side of
10 things.
11 CHAIR ROSENBAUM: Yes, Sharon.
12 COMMISSIONER CARTE: I was wondering about a
13 different aspect of this question, and that would be what
14 leverage would CMS have to describe data in different care
15 settings, going, say, from nursing facilities to
16 residential care settings.
17 For example, we know that states receive a
18 certain amount of monies for licensure and certification
19 activity, and would CMS be able to leverage some of that
20 perhaps to gather data. And I think we'll hear some
21 similar issues when we take up the serious mental illness
22 roundtable.

1 But when you look at the question of, for example,
2 cognitive decline for the elderly and how long they're able
3 to remain in a certain setting -- and Brian alluded to this
4 when you look at large assisted living facilities or
5 communities that have nursing homes embedded within them,
6 are we not, you know, in some ways, biased towards helping
7 people who probably wanted to remain more independent and
8 eventually end up in that nursing facility setting?
9 And I think -- I know that this data is not
10 clearly available now but I think we should start to think
11 about templating it out as to what is the length of time
12 that people stay in a particular setting and what affects
13 them changing. What are the transition nodes or the
14 reasons, the factors, that contribute the most to them
15 transitioning, like changes in mobility, falls, death? You
16 know, what are the reasons for discharge and change? What
17 are the lengths of stay? And I realize that there is a
18 real absence of that but a crying need, at the same time,
19 if we're really going to evaluate these different settings
20 and people's ability to remain in one.
21 Thanks.
22 CHAIR ROSENBAUM: Kit.

1 COMMISSIONER GORTON: First, I just -- I want to
2 make sure that we're careful that when we talk about
3 institutional settings we don't restrict it only to nursing
4 facilities. There are ICF/ORCs. There are ICF/ID-DD. And
5 if you look at the, for example, in the substance abuse
6 field, the ACM classification of the different levels of
7 24-hour facilities, and that leads me to the first
8 observation I want to make, which is, if we come at this
9 through the lens of aging, then the tendency seems to be
10 that you're on a one-way trip to a six-foot-deep hole. But
11 much of the institutional care is delivered to youth. Much
12 of the institutional care is delivered to people who are
13 dealing with ongoing chronic illnesses, who are learning to
14 manage disabilities. If you're newly blind it takes you a
15 long time to get -- to regain your independence, but we
16 shouldn't assume that, you know, you're going to toddle off
17 to the local school for the blind and never emerge.
18 So I think that there's not enough attention been
19 addressed to the continuum of these things, and really not
20 enough attention to how you move people through, because
21 part of the issue that we have is a coordination and
22 transition and throughout issue. People back up in

1 emergency rooms because they can't get inpatient beds. They
2 back up in inpatient beds because they can't get 24-hour
3 settings. They back up in the 24-hour settings because
4 they can't move to a, you know, a sober home or whatever
5 else, blah-blah-blah, all the way back down to the
6 community.
7 So I think it's important as the Commission
8 studies this that we keep in mind the panoply of
9 possibilities with respect to these settings.
10 So with that as preference, three answers to
11 Kristal’s questions. With respect to the rule, my
12 inclination is to say yeah, we probably should study it
13 further. I'm probably not the only person in the room who
14 didn't have the luxury of reading the rule, and I don't
15 feel deeply steeped in it.
16 EXECUTIVE DIRECTOR SCHWARTZ: We can provide that
17 opportunity.
18 [Laughter.]
19 COMMISSIONER GORTON: I'm worried about that.
20 But I'm hoping that in its usual exemplary fashion the
21 Commission staff will provide Cliff Notes and point us to a
22 faster path through the various aspects of the rule, as

1 you've done before. And so I would ask that, in the
2 future, the next time we revisit this, and I hope we will,
3 that maybe we can have a little primer on what's in the
4 rule and what changed.
5 I know that the whole issue around community life
6 is an important one, and I think it pays -- sometimes what
7 gets defined as community life historically, and I think
8 what I hear is that may still be the case under the rule,
9 is if you get to go to the movies with three paid staff
10 members and nine of your closest friends, then you have
11 participated in an inclusion activity and so you have a
12 real life.
13 So I do think that that's -- it's an issue in
14 rural communities but I think it's an issue in urban
15 settings, and I think it's an issue in suburban settings.
16 You know, everybody's experienced what has pejoratively
17 been called a mall therapy, where a group of people are
18 taken to a mall and sort of wheeled around for a little
19 while. And that doesn't create value for those
20 individuals, it doesn't create value for the mall, because
21 they don't usually buy anything, and it doesn't create
22 value for the community. So I do -- I think that's

1 probably worthy of attention. If we're going to include
2 people in communities then they really need to be included
3 in communities.
4 And so the -- your paper mentions the whole issue
5 of transportation and that's a place where I think that we
6 could afford to do more study. Some states, in certain
7 waivers, pay for some kinds of non-medical transportation.
8 It often doesn't get to a granular enough level that we can
9 take you to the faith community of your choice on the day
10 of the week which that faith community typically gets
11 together. And so if we can't meet something as fundamental
12 as people's faith needs, then it's hard for me to say,
13 yeah, we have them included in their community, and I think
14 transportation is often -- transportation and supervision
15 for people who need supervision is often an issue.
16 In answer to your second question, yeah, we
17 should study MLTSS more, and going back to the earlier
18 conversation, I do think the plans have a point of view,
19 and to the extent that people are not familiar with the
20 plan's point of view, my experience is that there are
21 precious few people who ever ask us.
22 And so I do think there's work that could be

1 done. And, you know, Marsha's point about confidentiality
2 and business, you know, proprietary stuff is there, but we
3 get around that when we need to.
4 And so I think there should be a consideration of
5 surveying the plans who are currently doing this. Brian
6 talked about best practices. I do think there are some of
7 those out there. Let's find out what the plans think work.
8 Let's ask the plans what they think are the barriers to
9 them doing a good job, and let's ask the plans where, if
10 they're in a state program that has facilitated their work,
11 that we can flag those things. I think that would be
12 useful to do.
13 The plans will also be able to tell you, in a
14 generic way, how they pay for these things. Is it a, you
15 know, global per diem? Is it some other bundled payment?
16 Are there elements of risk associated with those things?
17 And I think that would be useful for the Commission to
18 articulate.
19 And then, finally, the word "promote" -- the
20 "promote" word bothers me, because I'm not sure we should
21 be promoting anything. I think we should be offering
22 people choices, and we may not agree with the choices that

1 people make. What I do think we should focus on is what
2 are we doing that impedes. Right? So you, in the paper,
3 highlighted some policy barriers that impede the move
4 towards home- and community-based service settings.
5 You know, and I think it would be worth us
6 cataloging some of those impediments. For example, one of
7 the issues is if somebody has a placement in a setting, and
8 then they get sick and they go into the hospital, how do
9 you pay for that placement to be held until they get to go
10 home there? And that's -- it's an enormous challenge
11 because, you know, there's a fundamental tenet that goes
12 through Medicaid that you only pay for one thing on any
13 given day. And so how do you hold a place and not have it
14 evaporate, whether it's an individual's home, or their
15 apartment that they need to pay the rent, or, you know,
16 nursing home, or one of these other places.
17 So, you know, I think these are all topics that
18 we should get deeper into over the course of the next
19 several years.
20 EXECUTIVE DIRECTOR SCHWARTZ: Kristal, I wondered
21 if you wanted to just share, because it's not completely
22 obvious in the materials that came, what the role of plans

1 was in the case studies and also in our previous MLTSS site
2 visit. Could you comment on that a little bit?
3 MS. VARDAMAN: Sure. Of the states that were
4 included in the case studies, only one, Florida, had
5 managed care, and the experiences of the plans that -- or
6 the providers that we talked to there, the provider
7 community was mainly concerned about the rates and not
8 having experience negotiating with plans before, but there
9 wasn't much on the effects on access.
10 We didn't hear a lot from -- I think we
11 interviewed one plan in terms of what some of their
12 strategy was, but it's something that we could certainly
13 look more into in the future.
14 COMMISSIONER GORTON: Yeah, I guess what I would
15 say in terms of sort of ongoing methodological opportunity
16 is I think Toby and I can certainly potentially facilitate
17 a conversation between the Commission staff and the
18 relevant associations, to see if we can't get you an
19 opportunity to get more regular, better, high-grade
20 feedback from the plans. AHIP, historically -- America's
21 Health Insurance Plans, is the big commercial industry,
22 trade association -- traditionally has paid zero attention

1 to Medicaid. But in the last couple of years, with the
2 changes under the ACA, the expansion and everything else,
3 they've actually begun to staff up and they now have built
4 a whole new staff that are focused on Medicaid, and I think
5 Rhys came over to visit with you.

6 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. On the site
7 visits that we did, it's now been two years ago, correct?

8 COMMISSIONER GORTON: Correct.

9 EXECUTIVE DIRECTOR SCHWARTZ: We went to -- I
10 went with you to two places. Did we go to six places or
11 eight places?

12 MS. VARDAMAN: Five. We went to Florida,
13 Wisconsin, Illinois, Arizona, and --

14 EXECUTIVE DIRECTOR SCHWARTZ: -- Florida, right?

15 MS. VARDAMAN: Yes, we went to five places.

16 EXECUTIVE DIRECTOR SCHWARTZ: Yeah, and in all
17 those places we met with multiple plans.

18 MS. VARDAMAN: Yes. And in Wisconsin we met with
19 a residential care setting and they were the ones who did
20 bring up concern about the care coordination issue between
21 the plan care coordinators and those that were in the
22 facility.

1 Also, we are, actually -- I should note that for
2 the MLTSS network adequacy work, we haven't gotten to this
3 phase yet but we are planning to reach out to some plans,
4 once the contractor's looked at the current provisions and
5 contracts, to talk about some of the issues around building
6 a network. And so that's -- since -- you know, hopefully
7 we'll get some results from the contractor view and that
8 will help us determine what kinds of questions we'll ask
9 plans about residential care settings and other providers.
10 COMMISSIONER GORTON: Okay. Well, that's great.
11 I've noticed, over the six, eight months that I've been
12 doing this, that we seem to have this common theme of,
13 well, we don't know what's going on in the plans, and to
14 the extent that we can orchestrate a mechanism whereby we
15 get some visibility into what's going on in the plans, then
16 I would be happy to support that activity.
17 COMMISSIONER DOUGLAS: Just a brief question,
18 comment, as it relates on the MLTSS, relates to the
19 intersection with the mega-reg and the in-lieu-of services
20 and how that plays into this as well. Did that come up? I
21 mean, if we -- it's just an area to look at in terms of --
22 especially of looking at alternative ways to fund

1 residential care settings and room and board.

2 EXECUTIVE DIRECTOR SCHWARTZ: Sara had to step
3 out for a moment to take an urgent phone call. Does
4 anybody else have a question for Kristal? Leanna, you were
5 nodding your head in a couple of places. I wondered if
6 you'd have anything to add.

7 COMMISSIONER GEORGE: Well, being a parent who
8 has just recently, last month, placed my daughter in ICF, I
9 mean, it is huge area where we need more, I think,
10 attention, especially in the pediatric realms, as Kristal
11 was alluding to. In my state we may have 10 beds or slots
12 open a year, anywhere from 40 to 60 families trying to get
13 their child into that slot. The slot that my daughter is
14 currently in is 4-1/2 hours away from where I live at, so
15 it's like, when I want to visit here I might as well be
16 coming to D.C., because it's about the same drive for me to
17 get here as it is for me to go see her.

18 So, I mean, and as far as parent impact of, you
19 know, that, obviously, but without this level of support,
20 with the 7- to 10-year wait for home- and community-based
21 services waivers, you know, you look at the news, you hear
22 all these horror stories about, you know, families who are

1 at wit's end about what to do, they're stressed out.

2 Something definitely needs to be done, and we're
3 working towards that, but, you know, just from the -- when
4 the rubber meets the road it's a situation that needs to be
5 addressed.

6 CHAIR ROSENBAUM: Penny.

7 COMMISSIONER THOMPSON: That just takes me right
8 back to Marsha's initial comment about should we be
9 thinking more broadly about the question of what the
10 benefit structure ought to look like in the program, and
11 also, to Sharon's question about what do we know about
12 where people are, and to Kit's about how they back up in a
13 system, waiting for something to become available that is
14 really the thing that meets their needs.

15 I mean, we have these lines that we draw, you
16 know, and we talk about the fact that Medicaid isn't paying
17 -- isn't supposed to be paying, I think I would put it --
18 for room and board inside of HCBS settings, and this
19 question about how we relate the services that are needed
20 to the setting in which they're provided, and the desire
21 for settings to be qualified in a way that really reflects
22 their true nature. But also have, against that, this

1 question of what people who depend on the program are
2 really looking for and needing.
3 And I think if we can somehow even just begin to
4 array that and think about that in terms of long-term
5 services and supports in general, I think that could be of
6 great benefit for structuring further inquiry into some of
7 the narrower questions about particular settings and
8 characteristics and payment policy.
9 CHAIR ROSENBAUM: You know, I would be remiss not
10 to raise a point related to a number of the comments that
11 have come up. This happens to be an area of Medicaid where
12 there has been -- since the Olmstead case was decided,
13 which, of course, dealt with the relationship between the
14 Americans with Disabilities Act and Medicaid, and
15 essentially set certain parameters for how to think through
16 Medicaid long-term allocation decisions into home- and
17 community-based settings.
18 There has been a very, very extensive set of
19 Olmstead litigation, a huge number of cases, and I raise
20 the issue not so much -- most of the cases actually are
21 decided in the state's favor. But the interesting aspect
22 of these cases, which might be worth looking at, is that

1 you get a very extensive trial record. You get a lot of
2 information about the precise nature of the problems and
3 the barriers, and you get a very clear sense of the
4 different tools available to states to try and manage
5 resources in response to needs, and which ones, you know,
6 seem to fit more with the principles of the ADA, and which
7 ones do not.

8 But the cases I have found are extremely helpful
9 in elucidating just the points that we've all sort of tried
10 to make, which is what's the nature of the need, what is
11 the nature of the response, which are the services that are
12 just, you know, absolutely out of reach for most people
13 because there's just so little of them, and which are the
14 ones that they feel, themselves, are the services whose
15 lack thereof is keeping them in living arrangements that,
16 of course, are anything but community integrated.

17 So, again, not to get off on the legal side of
18 these cases but to get off on the factual and
19 circumstantial side of the cases, the records are quite
20 helpful in sort of guiding us through where we spend time.
21 And, of course, what comes out mostly is the same point
22 that's now been made several times, which is just these

1 tremendous waiting lists for certain kinds of services, and
2 those are the waiting lists that are known. So I -- and
3 it's not all room and board. You know, it's so many other
4 services, particularly for children who need integrated
5 educational settings.
6 Any other comments? Brian.
7 COMMISSIONER BURWELL: Two additional comments on
8 this issue of community integration. Community integration
9 is one of those things like everybody is behind it, but
10 there's more to it. And one of the issues that kind of has
11 come up in the expansion of home- and community-based
12 services has to do with the tension between safety and
13 risk.
14 So, by community integration, you mean people are
15 out in the community living normal lives, and people are
16 living in all kinds of residential settings. Inherently,
17 that creates more risk in the system. You have a lot more
18 different types of providers. You have foster care
19 arrangements, people living with individual families.
20 There's a lot of risk in life.
21 So there have been many instances in states where
22 states have done a good job developing those alternatives,

1 but then there are fires, and six people die, or there's
2 abuse. It's a more difficult system to monitor in regard
3 to safety. You're in a nursing home, and people express
4 this, "Well, I know my mother is safe there."
5 So it's a tension that I don't think has been
6 sufficiently acknowledged and is a difficult -- there's no
7 easy answer here.
8 Second issue of waiting lists, we've done work on
9 waiting lists. There are not good data on waiting lists.
10 You get on a waiting list. I mean, states keep waiting
11 lists, but they're not well managed. People put themselves
12 on six different waiting lists, or once you get on a
13 waiting list, you never get taken -- I mean, they don't
14 follow up. So there's just -- it's a really difficult
15 issue to get your arms around.
16 I think one fact that we do know is that there
17 are a lot more waiting lists for persons with intellectual
18 disabilities than for the aged. So there's a lot more
19 excessive demand on the non-elderly side than on the
20 elderly side for home- and community-based services.
21 CHAIR ROSENBAUM: Yes. And, in fact, most
22 litigation does not involve older beneficiaries at all. It

1 involves younger people.

2 All right. We do have time for a couple

3 comments.

4 **### PUBLIC COMMENT**

5 * [No response.]

6 CHAIR ROSENBAUM: Hearing none, we are adjourned

7 until one o'clock.

8 * [Whereupon, at 11:56 a.m., the meeting was

9 recessed, to reconvene at 1:00 p.m., this same day.]

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1 AFTERNOON SESSION

2 [1:09 p.m.]

3 VICE CHAIR GOLD: Okay. I think we'll get
4 started. Sara had to step out for a couple of minutes, so
5 I'm going to moderate this part of the session.

6 Katie Weider is going to talk to us about a
7 roundtable that the Commission convened on improving
8 service delivery for Medicaid beneficiaries with serious
9 mental illness, so I'll let Katie describe it. And then
10 both Toby and Andy attended that session, so before we get
11 into general discussion, we'll ask them if they want to add
12 anything to it.

13 All yours, Katie.

14 ### **IMPROVING SERVICE DELIVERY TO MEDICAID**
15 **BENEFICIARIES WITH SERIOUS MENTAL ILLNESS: THEMES**
16 **FROM ROUNDTABLE DISCUSSION**

17 * MS. WEIDER: Great. Thanks, Marsha.

18 So, again, today I will be presenting on themes
19 from a roundtable we had this past June on improving
20 service delivery for Medicaid beneficiaries with serious
21 mental illness. But before I get into the details of the
22 roundtable discussion, I will just first briefly review our

1 past work relating to behavioral health.

2 As the Commission will recall, in our June 2015
3 report to Congress, we had a chapter focusing on the
4 prevalence and expenditures of behavioral health conditions
5 and Medicaid. Following that chapter, in our March 2016
6 report to Congress, we documented behavioral and physical
7 health integration activities in the Medicaid program. And
8 most recently, this past July, we published a state-by-
9 state review of Medicaid's coverage of mental health and
10 substance abuse disorder services.

11 Building from our past work, in late 2015 the
12 Commission suggested convening an expert panel on the
13 barriers to delivering behavioral health services in
14 Medicaid. In June 2016, we held that roundtable, which
15 focused on improving issues relating to service delivery
16 for Medicaid adults with serious mental illness.

17 At that roundtable we had 15 experts. They
18 ranged from state Medicaid directors, CMS, SAMHSA, and ASPE
19 representatives, state behavioral health agencies, managed
20 care organizations, providers, and advocates. We also had
21 three Commissioners attend the meeting: Commissioners
22 Cohen, Douglas, and Rogers.

1 For the meeting, we focused on a few discussion
2 questions, including identifying gaps in knowledge on
3 Medicaid adults with SMI, barriers to access, and potential
4 Medicaid policy solutions for improving behavioral health
5 service delivery. And from those questions, the expert
6 panel identified six major themes.
7 One of the major takeaways from the discussion
8 was that more research is needed on Medicaid beneficiaries
9 with SMI. Throughout the roundtable discussion, it was
10 frequently highlighted that there's limited information
11 available on adult Medicaid beneficiaries with SMI.
12 Additionally, there is a lack of standardized definitions
13 and measures, which makes it difficult to compare and
14 assess the effects of interventions when research is
15 available. And here we've highlighted some of the
16 potential research topic areas that were raised during the
17 meeting, which I will discuss later on.
18 Although the discussion was intended to focus on
19 adult beneficiaries with SMI, many participants underscored
20 the need to address youth with emerging symptoms of SMI and
21 severe emotional disturbance, SED. They also highlighted
22 the importance of early detection, screening, and

1 prevention programs, and this was a theme that the
2 roundtable continued to circle back on throughout the
3 discussion.
4 In order to improve early intervention services
5 and also address emerging symptoms of SMI, the panelists
6 suggested improving coordination with the education system
7 and using the free care rule to provide and increase access
8 to behavioral health services.
9 Our third theme was that there are opportunities
10 in Medicaid to promote more consistent and comprehensive
11 coverage of physical and mental health services for
12 individuals with SMI. The discussion focused on three
13 areas that the Medicaid program could use to expand
14 behavioral health services. First, panelists suggested
15 creating a new optional benefit under a Medicaid state
16 plan, specifically creating a new benefit category for
17 mental health and substance use disorder services. This
18 category could be used instead of relying on the rehab
19 option to provide behavioral health services.
20 Panelists also highlighted the certified
21 community behavioral health clinics demonstration program.
22 This demonstration is designed to provide a comprehensive

1 range of mental health and substance use disorder services.
2 Additionally, states can receive enhanced Medicaid federal
3 match for the services delivered by these clinics. Since
4 this initiative is new, it offers an opportunity to examine
5 how this model can improve delivery of behavioral health
6 services for individuals with SMI.
7 And, finally, with the increasing movement
8 towards Medicaid managed care, participants discussed that
9 managed care organizations have the opportunity to provide
10 specialized networks and services to individuals with SMI.
11 They encourage continuing monitoring of Medicaid managed
12 care organizations serving individuals with SMI.
13 The fourth theme that came out of the roundtable
14 discussion was that adult beneficiaries with SMI face many
15 challenges accessing appropriate behavioral health
16 services. They noted that this was a multifaceted issue
17 and emphasized a few methods for improving access to care.
18 These included increasing the number and improving the
19 distribution of behavioral health providers participating
20 in the Medicaid program; increasing the availability of
21 Medicaid-covered crisis intervention and community-based
22 services; improving the understanding of federal and state

1 policies on data sharing; and conducting additional
2 research on provider networks in Medicaid managed care.
3 Participants also noted that some rules and
4 regulations governing Medicaid payment may create barriers
5 for Medicaid adults with SMI to receive necessary services.
6 They noted that some states prohibit providers from billing
7 for both behavioral health and physical health service
8 visits on the same day. Removing these provisions would
9 likely benefit beneficiaries with SMI.
10 Additionally, states often limit the type of
11 providers who can bill Medicaid for behavioral health
12 services. As a result, certain providers, such as peer
13 counselors, cannot bill Medicaid. Participants suggested a
14 need for a comprehensive review of licensure requirements
15 for Medicaid providers and changes in policy to reflect
16 current behavioral health practice.
17 And, finally, they stated that additional
18 research needs to be conducted on who is receiving care in
19 the institutions for mental disease, IMDs; what services
20 IMDs are providing; and the effects of the Medicaid IMD
21 exclusion on access to care for Medicaid adults.
22 Participants noted the heterogeneity of IMD facilities, and

1 they noted that IMDs can be classified into five major
2 categories: one, acute psychiatric hospitals; two,
3 substance abuse treatment centers; three, long-term-care
4 institutions; four, nursing homes; and, five, boarding care
5 homes.
6 Participants suggested that future studies should
7 focus on how the Medicaid IMD exclusion affects the varying
8 populations served in these different facility types. They
9 also noted that this research should be conducted before
10 policy changes are made to the IMD exclusion.
11 The last major theme that came out of the
12 roundtable discussion was that adult beneficiaries with SMI
13 face multifaceted health and social needs. As a result,
14 they use many other programs in addition to Medicaid, which
15 complicates the delivery of the services they receive.
16 Throughout the discussion, participants
17 emphasized that better coordination between Medicaid,
18 housing, criminal justice, and education programs were
19 needed. They also stressed a need for a better
20 understanding of how these programs work in concert and in
21 conflict with each other and identification of how these
22 programs fill in each other's gaps.

1 Many of the themes that were highlighted in the
2 roundtable supported our past and ongoing work related to
3 behavioral health. On these next two slides, we list some
4 of the questions we're seeking to answer relating to
5 behavioral health.
6 The first set of questions here focuses on
7 Medicaid's flexibility to improve service delivery. The
8 first question -- How does Medicaid's coverage of
9 behavioral health services differ across states? -- was a
10 knowledge gap that was specifically raised during the
11 meeting, and we're actually very pleased it was raised
12 because at the time of the roundtable, we were almost
13 complete with our state-by-state review of behavioral
14 health coverage in the Medicaid program. So this document
15 is currently on our website, and we believe that we're
16 aligned with the expert panel on this issue.
17 The second group of questions relates to payment
18 and provider participation. We are currently undergoing
19 work to identify who are the behavioral health providers
20 serving Medicaid beneficiaries and what payment policies
21 affect their participation and provision of care.
22 Third here is that we have begun our work to look

1 into how the Medicaid program intersects with other
2 programs, specifically looking at how programs work
3 together, in conflict with each other, and how they deliver
4 overlapping and varying services.
5 And, finally, we have our analyses relating to
6 access and quality of care. We are building off of our
7 June 2015 chapter and taking a deeper dive into behavioral
8 health utilization and spending, specifically looking at
9 spending and utilization by diagnosis, place of care, and
10 provider type, and how this varies across Medicaid programs
11 and by subpopulation.
12 We are also looking at dually eligible
13 beneficiaries' utilization and coverage of behavioral
14 health services, and we are also examining spending
15 patterns of behavioral health and physical health services
16 for individuals with behavioral health conditions.
17 So there were a range of topics covered at the
18 roundtable discussion, and we believe many of the key
19 themes align with our past and ongoing work. So I look
20 forward to your comments and can take any questions.
21 VICE CHAIR GOLD: Thank you, Katie.
22 COMMISSIONER DOUGLAS: Thank you, Katie, and

1 great summation of the report and the presentation, very
2 lively discussion, and meeting that we had with lots of
3 different points of views, and this really did a great job
4 of putting it into the various themes.
5 What I'd say, I mean, really just in summation of
6 the themes, I think that MACPAC -- that our approach on
7 where we go from research and analysis is the right way
8 that we -- you know, there are so many different
9 interventions that were raised, but really it comes down to
10 we have got to get a better understanding and keep on
11 presenting the data, especially on the access front, and
12 really understanding where spending is going for those with
13 behavioral health to really get a better sense of what
14 interventions are going to work from a Medicaid perspective
15 of physician and behavioral health, and the spending. So I
16 think looking at that, looking at understanding areas of
17 the payment and incentives on providers for behavioral
18 health, so sticking to what we're doing will help address -
19 - it won't address all these themes, but will give us a
20 sense based on that data where some of these themes can
21 actually be effective.
22 COMMISSIONER COHEN: I have a very similar kind

1 of reaction to Toby, so, first of all, really great job on
2 the summary. It was a very hard job. The phenomenal array
3 of experts around that table, huge degree of enthusiasm
4 that there is a lot of opportunity to improve behavioral
5 health services for Medicaid beneficiaries, recognition
6 that Medicaid is a huge driver of potentially positive
7 change in this space. But I will say no coalescing around
8 what the sort of key challenges are or the key sort of
9 policy levers. And I think that was -- you know, one of
10 the tough things is that there are so many challenges in
11 this space, but they are not that well documented in a
12 standardized way. Love what's up on the MACPAC website,
13 but it doesn't include what's in waivers, and so much of
14 what's done in Medicaid for the seriously mentally ill is
15 done under waivers. So it's not standardized. The data
16 collection I think is different. And it is just really
17 hard to sort of even identify by data what the real
18 challenges are, although everyone in the room could tell
19 you a thousand challenges with, you know, sort of examples.
20 The issues of state law and licensing, really
21 significant. The issues of workforce, so significant. The
22 issues of just sort of where the clinical research is and

1 where the -- you know, I would just say like comparative
2 effectiveness and other kind of research is, also
3 challenges, and not necessarily ones where Medicaid policy
4 can lead and make a difference.
5 So I think one of our big challenges is to sort
6 of tease out what are promising opportunities where
7 Medicaid policy specifically, especially payment policy,
8 can really make a difference.
9 I agree, looking at issues of, you know, policies
10 around billing on the same day and other things might be a
11 fruitful place to start integrating financing and making
12 sure there aren't unintended sort of erroneous incentives
13 by the fact that we pay one group of providers in separate
14 buckets in many states than we do other groups of
15 providers, and then data, data, data, data, really figuring
16 out what the top priority in terms of how do you figure out
17 what the access issues are and access to what, because
18 everybody, I think, in that room said something about there
19 being issues around access to the right kinds of services,
20 right time, right place, right setting, but there was very
21 little data to back it up.
22 COMMISSIONER GORTON: So building on what Andy

1 was saying with respect to the access question, one place
2 where there's really not a lot of information is people
3 with co-occurring illness, right? We will often study are
4 there enough residential settings for people with SMI.
5 What we don't do is look at, well, but if because of the
6 atypical antipsychotics this person has been on for ten
7 years, they also have metabolic syndrome, diabetes, high
8 blood pressure, right? You call a behavioral health
9 residential provider and you say, "We've got this person
10 who's perfect for your program," and they say, "Well, we
11 don't know anything about diabetes." And so, you know,
12 okay, that means he can't come, right? You know, children
13 with eating disorders who also have substance use, you
14 know, the stuff tends to co-occur. And the interventions
15 have often been built in silos.
16 So on my team, we talk about you go to a provider
17 and you say, "What kind of services do you provide?" They
18 say, "I'm a red crayon." You say, "What do you do if your
19 patient needs a blue crayon?" They say, "I'm a red
20 crayon." So there's work that needs to be done for people
21 who need the whole eight colors or people who need a box of
22 64.

1 And so I would be interested in seeing some
2 analysis on not just access to siloed services aligned with
3 single diagnoses, but on access to coordinated services for
4 multiple diagnoses. I suspect that we'll find that there's
5 precious little out there, but I do think that we ought to
6 try and cast a light on that, because people are not
7 building those integrated complex services. They are
8 building inpatient detox beds for substance use disorder.
9 The second thing, in Theme 3 I would be
10 interested -- historically, the 1915(c) waivers have been
11 very condition-specific. You could be in an aging waiver;
12 you could be in an HIV waiver; you could be in a DD waiver.
13 But God forbid you were an old person with DD who had post-
14 traumatic stress from living in an institution for 40
15 years. There was no way to get you all of the right sets
16 of services because the service you need for your PTSD is
17 over there in the SMI waiver, right?
18 So I would be interested -- and I don't know that
19 I've ever seen this -- in looking at where states have used
20 1115 authority to maybe mesh stuff together -- I don't know
21 if they have -- or if states have been able to be creative
22 with 1915(c) authority or others to try to pull things

1 together.

2 I know living in managed care in 1915(b) land, we
3 run into these barriers all over the place, and so I think
4 it might be useful, if there are best practices out there
5 on how to try and make these things line up, to elucidate
6 that; and if there are not, then to identify the barriers
7 for why nobody has come up with the best practices, because
8 these are obviously pressing problems.

9 And then the third piece -- and maybe this came
10 up and you just didn't have space in what was a summary of
11 what seems like a very meaty meeting. But I was surprised
12 that race, language, ethnicity didn't come up, cultural
13 competency didn't come up in Theme 6, because it is
14 incredibly difficult, particularly for people with limited
15 English proficiency, to even begin to be addressed by the
16 behavioral health system, right? So, you know, you have
17 people who have come across from China in containers. They
18 only speak Mandarin or Cantonese. They come from a culture
19 where the stigma associated with mental illness is
20 profound, and the last thing they want to do is tell
21 somebody they're thinking about killing themselves. And
22 then they need specialized treatment for PTSD.

1 And so, you know, or we have a set of Ugandan
2 refugees in central Massachusetts. They speak Swahili.
3 Many of the women have been gang raped in conflict zones.
4 So these are people who are confronting some pretty
5 incredible stuff, and if we can't come up with a culturally
6 competent way to address their needs, then what happens is
7 they live their silent horrors off by themselves.
8 And so I would be interested in, again, can the
9 Commission either elucidate best practices in dealing with
10 limited English proficiency and other cultural competency
11 issues on the behavioral health side, or if there are best
12 practices, to point those out to other people.
13 VICE CHAIR GOLD: Yeah. Sharon.
14 COMMISSIONER CARTE: In looking at the question
15 about what we know and don't know about Medicaid enrollees
16 with SMI, it seems like a really essential question. I
17 think it was a GAO report of about a year or two ago that
18 talks about this relatively small percentage of SMI
19 enrollees in Medicaid, around 5 percent, but utilizing 20
20 percent of expenditures in Medicaid. And that kind of
21 spread just tells you that we really need to have more
22 data. It seems like it would be in the interest of all the

1 states and CMS to be able to have a measure that indicates
2 the denominator of all people by state and a numerator for
3 those people who are getting -- SMI folks who are getting
4 services. And that would include the home- and community-
5 based folks that Andy talked about, and that we would
6 further be able to look at the data for the intensity of
7 services received by those folks as well as the setting
8 which they receive it would be important parameters.
9 VICE CHAIR GOLD: Katie, people have had a number
10 of comments. Was there anything that you wanted to ask or
11 react to?
12 MS. WEIDER: No, not at this time.
13 VICE CHAIR GOLD: One suggestion I had was, as
14 you look at this utilization data, think about the "so
15 what?" question that will come afterwards, and I don't know
16 if there are any metrics that have guidelines or
17 suggestions as to what's better or worse access or better
18 or worse care that you could build in or maybe just look at
19 some surveys that if they're specific to this group that
20 you could combine them with, because the numbers are
21 useful, but often they raise as many questions as they
22 don't. And if we can anticipate sort of the normative

1 thing about are there gaps -- Sharon?

2 COMMISSIONER CARTE: I should add that the

3 impetus behind those questions, Katie, comes from looking

4 at Washington State, where they're starting to look at

5 these issues, and because we've turned over so much of the

6 care to managed care, that they're looking at using these

7 kinds of measures, both towards determining case mix and

8 acuity, and also penetration, how many services when you

9 have that numerator and denominator it's showing you. And

10 you can look either by your regional services or by MCO,

11 what kind of penetration you're seeing for this population.

12 VICE CHAIR GOLD: Any other comments on this

13 topic?

14 [No response.]

15 VICE CHAIR GOLD: All yours, Sara.

16 CHAIR ROSENBAUM: All right. So we are now

17 turning to Tab 6 for a discussion about Medicaid financing

18 and provider payment policies with Moira and Chris.

19 [Pause.]

20 **### THE RELATIONSHIP BETWEEN MEDICAID FINANCING AND**

21 **PROVIDER PAYMENT POLICIES**

22 * MS. FORBES: Thanks. So thank you. I felt like

1 so -- additional three feet, really very far away.
2 So the Commission has been discussing Medicaid
3 financing partly in response to concerns raised by policy-
4 makers about the level and rate of growth of Medicaid
5 spending. Medicaid is, of course, financed by both states
6 and the federal government.
7 Earlier this year, we focused a lot on
8 alternatives to the federal financing approach. Today,
9 we're going to talk more about the non-federal financing
10 side of things -- or state share and in particular how this
11 relates to Medicaid payment policies, and we'll note some
12 of the implications that this raises for future Medicaid
13 policy.
14 Medicaid financing is structured so that federal
15 funding is available to match state contributions. As you
16 recall, last June, the Commission published a report
17 chapter on federal financing and options for systems that
18 limit federal contributions, including block grants, capped
19 allotments, per capita caps, and shared savings
20 arrangements.
21 Medicaid has always been financed through both
22 federal and non-federal contributions. The non-federal

1 portion can be generated through a variety of mechanisms.
2 This reflects the various systems for providing health care
3 for low-income populations that were in existence at the
4 time that Medicaid first came into existence and were used
5 by states at the time.
6 Some of these are listed on the slide here. They
7 include general revenue, CPEs and IGTs, and provider taxes.
8 There are limitations on some of these
9 mechanisms. For example, 40 percent of non-federal funding
10 must come from the state and not from local or provider
11 contributions. Congress has imposed some restrictions on
12 some of these sources over time. For example, health care-
13 related taxes must be broad-based and uniform. They cannot
14 hold providers harmless. Sources of non-federal financing
15 are subject to federal oversight, although CMS has noted
16 that the data it collects on sources of non-federal share
17 are unreliable. And states vary a lot in their uses of the
18 different mechanisms, as we'll talk about a little more on
19 the next few slides.
20 These data come from a 2014 survey that GAO
21 conducted, which is the best source of information
22 currently available. As you can see, the majority of the

1 non-federal share of Medicaid spending is from state funds,
2 mostly state general funds. About a quarter of Medicaid
3 spending is from local and provider contributions, and a
4 small amount is from other sources.

5 The previous slide showed that states overall
6 financed about a quarter of the non-federal share with
7 contributions from providers and local governments. This
8 map shows, like so many of the things that we talk about,
9 the extent to which the non-federal share comes from local
10 and provider contributions varies a lot by state, from zero
11 percent to just over 50 percent, according to the data
12 collected by the GAO.

13 The GAO survey asked states about sources of
14 state share over time and found that state use of
15 contributions from providers and local governments as a
16 source of non-federal share has increased over time, while
17 the use of state funds has decreased.

18 The GAO also found that the percentage of the
19 non-federal share of supplemental payments financed with
20 local and provider contributions has been relatively high
21 and is increasing.

22 From this set of facts, there are two different

1 interpretations that are at odds with each other. One
2 view, which states generally hold, is that states are
3 making effective use of all legally permissible funding
4 sources to generate revenue to support the Medicaid
5 program. The other perspective is that states are using
6 funds from providers and local governments to inflate
7 federal contributions in the overall Medicaid budget
8 without additional state contributions. As you can see,
9 that second perspective is played out in some federal
10 policy responses described in the next slide.
11 In response to the concern about the effect of
12 the increased use of local and provider contributions on
13 overall Medicaid spending, various ideas have been proposed
14 that would disallow or limit specific sources of non-
15 federal share. For example, local contributions such as
16 intergovernmental transfers or certified public
17 expenditures could be disallowed, or the Medicaid provider
18 text threshold could be reduced below the existing law
19 level of 6 percent.
20 It's not clear what effects these policies would
21 have on states that rely on these sources in part because,
22 as noted earlier, there's not much information on the

1 extent to which states currently rely on these sources of
2 revenue to generate their non-federal share of Medicaid
3 spending, and we don't know what alternatives states would
4 use if any of these sources were disallowed.
5 However, we used available data, as Chris will
6 discuss on the next few slides, to estimate how the
7 increased use of these financing mechanisms affects the
8 split of federal and state funds nationally.
9 * MR. PARK: Thanks.
10 To estimate how state financing options affect
11 the split of federal and state funds, we used the GAO
12 survey data on the extent to which each state uses various
13 sources of non-federal financing.
14 We tried to estimate how much of the non-federal
15 share was contributed by providers and local governments
16 and then returned to those providers through provider
17 payments, because these provider contributions do not
18 necessarily contribute to the net payment that the provider
19 ultimately receives, and any increases in the provider
20 payment associated with this source of financing are
21 largely funded through federal dollars.
22 We do not simply want to remove all of the

1 dollars associated with these provider contributions from
2 providers and local governments. In certain cases, these
3 dollars do not necessarily go back to the providers. For
4 example, the amount contributed through provider tax, this
5 generally goes back to providers. However, an example is
6 Colorado where they do have a hospital provider tax, but
7 they use some of their provider tax revenue to fund an
8 eligibility expansion. So we made some assumptions about
9 how much of the different sources of non-federal share were
10 returned to providers and apply these assumptions to the
11 CMS-64, financial management report data, to estimate the
12 amount of federal spending associated with this portion of
13 the non-federal share.
14 From this analysis, we found that there was a
15 modest increase in overall federal share, once you adjust
16 for provider contributions. The average federal matching
17 rate, that is, the ratio of total federal spending to total
18 Medicaid spending, is about 57 percent in 2012. We've
19 removed the non-federal share contributed by and returned
20 to providers from total spending and recalculated this
21 ratio. Once we have recalculated this, the federal portion
22 was about 61.7 percent, or about 4.7 percentage points

1 above the average federal matching rate that we saw before.
2 Of course, there was substantial variation across
3 states. So this graph shows the distribution of states by
4 the percentage point increase in the federal portion of
5 total spending once we made the exclusion for provider
6 contributions.
7 As you can see, the majority of the states, 31
8 states, have between a zero to 4 percent increase in the
9 federal share. You can also see that any policy changes
10 that affects how states can raise the non-federal share
11 would have a greatly different effect, depending on which
12 state you're talking about.
13 MS. FORBES: So just to pull together some of the
14 facts from this presentation and also that were discussed
15 earlier today, contributions from providers and local
16 governments are an important component of Medicaid
17 financing. On Slide 6, we showed that states financed
18 about a quarter of non-federal share from health care
19 providers and local governments, and as the GAO found,
20 funds from providers and local governments have increased
21 as a percentage of the non-federal share, while state funds
22 have decreased.

1 Supplemental payments account for a large
2 proportion of total hospital payments and are increasingly
3 financed through provider contributions. MACStats data
4 from 2014 showed that supplemental payments account for
5 about 44 percent of total hospital payments, and again, the
6 GAO found that the percentage of the non-federal share of
7 supplemental payments financed with funds from providers
8 and local governments has increased.
9 As we showed in the hospital index analysis this
10 morning, Medicaid hospital payments, net of both
11 supplemental payments and provider contributions, are not
12 excessive relative to cost or compared to Medicare
13 payments.
14 And, finally, when we look at all of this
15 together, the relationship between the state approach to
16 financing non-federal share and provider payment policies,
17 including supplemental payment policies, is complex and
18 raises two sets of linked policy issues.
19 Some of the policy implications to consider
20 include:
21 The changes to the federal financing structure
22 will have to address whether existing differences in

1 underlying state financing approach would be preserved or
2 phased out.
3 The states currently exercise flexibility to
4 generate revenue to support their programs that results in,
5 as we saw in the map, a lot of differences among states in
6 how they finance their programs.
7 That financing mechanisms raise questions about
8 accountability and transparency, particularly when there's
9 little data available at the provider level, as we've
10 mentioned several times today.
11 On the payment side, we continue to find that the
12 use of supplemental payments complicates efforts to tie
13 payments to value, and while we didn't get into managed
14 care here, the rule that came out this summer largely
15 maintains the explicit prohibition on making supplemental
16 payments to providers outside of capitation, which requires
17 states and CMS to go through the waiver process to keep
18 that money in the system, which adds complexity.
19 So we hope this information is helpful as the
20 Commission continues its discussions on Medicaid financing
21 and payment policy. We realize this is just the start of a
22 conversation, and there may be more open-ended issues or

1 there may be specific things for us to follow up on. We
2 thought that, first, Chris can answer any technical
3 questions you might have on the analysis, and then we're
4 happy to answer whatever else we can.
5 CHAIR ROSENBAUM: Penny, will you lead us off,
6 and then we'll take it from there.
7 COMMISSIONER THOMPSON: Sure. So we'll start
8 with the technical side. First of all, thank you very
9 much. I've been dying for this conversation.
10 Just to review the trend lines, you referenced
11 2008 to 2012 when local government and provider funds
12 increased and increased as a share of the supplemental
13 payments. Do we attribute that to states under fiscal
14 pressure from the economic downturn, looking for other
15 resources of revenue?
16 MR. PARK: So that data came from the results of
17 the GAO survey, and I think that is one of the factors they
18 mentioned that would contribute to that trend, is that
19 during that fiscal downturn, they started using these
20 different sources of contributions more.
21 COMMISSIONER THOMPSON: Okay. When we talk about
22 the two different views on what this means, it seems to me

1 that, actually, those can both be true. It can be true
2 that states are using all legally permissible means at
3 their disposal, just as we as taxpayers try to take
4 advantage of everything the Tax Code has to offer us and,
5 in so doing, maximize finances to our advantage.
6 I want to ask a little bit about this calculation
7 that you're doing and the judgments that you made about
8 what was and was not returned to the provider. This is a
9 little bit of what we started talking about earlier today.
10 I mean, to some extent, it almost feels to me like a
11 formula that answers itself, which is if you take out a
12 source of funds and you take out payments and you only
13 leave in the federal share, it will naturally inflate the
14 federal match. You are talking about the elements that are
15 actually on one side of the equation, and you're leaving in
16 the element that's on the other side of the equation. So,
17 by necessity, it will have that result. So I think we need
18 to scrutinize and examine how we made the decision about
19 what we're taking out.
20 So I understand taking out provider contributions
21 because that's what we're testing.
22 MR. PARK: Sure.

1 COMMISSIONER THOMPSON: But you're also taking
2 out expenditures made under federal and state rules about
3 what constitutes a permissible expenditure to the providers
4 that were also the source of the funds, but those
5 expenditures may have produced value to the Medicaid
6 program. They may have represented a payment. In fact, by
7 necessity, they did. They represented something that the
8 Medicaid program thought it was getting as a result of that
9 expenditure for which the federal match was allowable.
10 So can you talk a little bit about what you put
11 on what side of the ledger for an expenditure that you left
12 in and an expenditure that you took out?
13 MR. PARK: Sure. We made some very high-level
14 assumptions because we don't have very detailed information
15 about exactly how every state uses provider taxes or CPEs
16 or IGTs. So we can't make very detailed assumptions at the
17 state level.
18 What we wanted to try to do is -- we've looked at
19 a few states to try to get a sense of how they're using the
20 different sources of funds and make assumptions about
21 whether those particular sources, such as provider taxes,
22 have a strong link to the provider making that

1 contribution, and then in an aggregate sense across all
2 providers of that class, they are getting most of that
3 money back alongside the federal share.
4 We try to make this calculation based on this
5 viewpoint that -- the second kind of viewpoint where states
6 are able to make increased payments to these providers
7 because they are able to draw down that additional federal
8 share. So, when you look at what the provider contributed
9 and then got back, they really only netted basically the
10 federal share at the end of the day, and so this gets to
11 that second viewpoint of that.
12 The states are able to increase provider payments
13 for very valid purposes in most circumstances, to increase
14 access or provide incentive payments to hospitals, better
15 quality, but if you look at it from that one viewpoint,
16 then the federal dollars are a greater percentage of the
17 payments to those providers than what you would typically
18 expect for the normal FMAP rate. That was what we are
19 trying to do with this calculation. We are making very
20 gross assumptions. So, to that point, there are very valid
21 assumptions plus or minus from where we've made them as to
22 whether the contributions from providers or from local

1 governments are kind of being used in that purpose versus
2 being used in a more general sense to support the entire
3 Medicaid program and doesn't have as direct of a link back
4 to the provider.
5 EXECUTIVE DIRECTOR SCHWARTZ: Chris, it's correct
6 that we have a different assumption for each source of
7 revenue?
8 MR. PARK: Yes.
9 EXECUTIVE DIRECTOR SCHWARTZ: Because we are
10 trying to set up the broader discussion here, we didn't
11 give you all that documentation, but we can. We can also
12 do sensitivity analysis about those assumptions, and so
13 before we go further with this, we can certainly share some
14 of that with you. And there's documentation for each
15 assumption and why it's higher or lower for a particular
16 source.
17 VICE CHAIR GOLD: Can I ask a clarifying
18 question?
19 MR. PARK: Sure.
20 VICE CHAIR GOLD: Because I'm sort of confused
21 with the two parts of the analysis. In one you're talking
22 about provider payments and intergovernmental transfers,

1 and then here it seems like you're talking about provider
2 payments. And I actually agree that it's important to make
3 the distinction among them, but I want to make sure I
4 understand what you -- which part of the ball you're taking
5 out. And I think we have to be careful around the language
6 not to mess -- get it all mixed up, because each of these
7 things can be looked at in different ways from a policy
8 perspective.

9 MR. PARK: Sure, and, you know, this is where the
10 assumptions came into play. So we didn't want to simply
11 remove all the non-federal share that were associated with
12 provider taxes or contributions from local governments,
13 because, you know, not all of these sources are directly
14 tied to a payment policy. You know, they could be used to
15 support, like administrative services that the state
16 provides, or as in the case of Colorado, they used some of
17 that money to support eligibility expansion.

18 So at a certain point -- and this is a very fine
19 distinction and one that, you know, people will definitely
20 argue about, and, you know, why we are making some very
21 gross assumptions at this point but we can provide
22 sensitivity analysis around it.

1 EXECUTIVE DIRECTOR SCHWARTZ: And also, we're
2 still doing this at the aggregate level, so to Penny's
3 point, about, you know, there have to be winners and
4 losers, what we're still seeing is at the aggregate level
5 there's a gain, even if at the institutional level it's not
6 a quid pro quo.
7 COMMISSIONER THOMPSON: So it is fair, then, to
8 describe this as almost our analysis is kind of the worst
9 case scenario for what the implication is to the federal
10 side, that if you believe that the funds that the providers
11 are giving the state to use as its state share are drawing
12 down federal dollars for expenditures that have little to
13 no value other than to make the provider pull, who provided
14 the initial contribution, that this is the effect?
15 MR. PARK: I wouldn't say it's the worst case,
16 because we didn't -- for example, we could have assumed
17 that all provider tax dollars were being returned back to
18 the provider.
19 COMMISSIONER THOMPSON: Well, that's kind of an
20 extreme case.
21 MR. PARK: Right.
22 COMMISSIONER THOMPSON: I mean, like a rational

1 worst case --

2 MR. PARK: Yes.

3 COMMISSIONER THOMPSON: -- like our idea of a

4 worst case would be this --

5 MR. PARK: Yes.

6 COMMISSIONER THOMPSON: -- because it presumes

7 those dollars that came back to the provider really brought

8 nothing of value to the Medicaid program.

9 EXECUTIVE DIRECTOR SCHWARTZ: But that's not what

10 we're saying, Penny. I mean, you added in adding no value

11 to the Medicaid program and we didn't make a judgment about

12 that. You're saying it's a question of whether --

13 COMMISSIONER THOMPSON: That's what's implicit in

14 taking it out of the equation, in my view, because what

15 we're saying is there was a federal share that was

16 generated as a result of the provider contribution. The

17 expenditure that that federal match was matching, that

18 those federal dollars were matching, was -- we're using the

19 word "returned to the provider." If it had gone to, say, a

20 provider that didn't provide that contribution, we would

21 have said it belonged still in the equation because it

22 bought something.

1 So that's my point, which is implicit in the
2 analysis is the idea that the return to the provider is
3 effectively in recognition of the contribution, as opposed
4 to what a supplemental payment or other kind of payment
5 would need to qualify for, which is for a certain service
6 or activity, of value to the Medicaid program.
7 MR. PARK: Yeah, so I think the way -- you know,
8 this kind of links back to the hospital payment index --
9 COMMISSIONER THOMPSON: Right.
10 MR. PARK: -- in terms of how does this actually
11 contribute to the net payment that provider has received.
12 And so if some of the tax dollars went to a different
13 provider class --
14 COMMISSIONER THOMPSON: Mm-hmm.
15 MR. PARK: -- that did contribute to the net
16 payment. So that particular source of non-federal share
17 did contribute to the net payment of another provider.
18 If it went from, you know, one provider class and
19 was returned back to that provider class, in general, then
20 it didn't necessarily contribute to the net payment and the
21 federal portion of the dollars that went -- you know, in
22 terms of the net payment, were higher. And so that is kind

1 of the calculation that we made.

2 And so, to Anne's point, you know, we weren't

3 necessarily trying to make a value judgment that, you know,

4 these were not justified or there is no value associated

5 with it. It's that, you know, federal dollars at the net

6 level were a little bit more because of the way that it was

7 financed.

8 COMMISSIONER THOMPSON: Why don't I stop there

9 and see if others want to jump in on those technical

10 points.

11 CHAIR ROSENBAUM: So I have Alan and I have Andy,

12 I have Marsha, Toby.

13 COMMISSIONER WEIL: I don't know if this

14 qualifies as jumping on a technical point. I think I share

15 some of Penny's concerns, although I wouldn't frame it

16 quite the same way about no value.

17 I get hung up on the language also but maybe in a

18 slightly different way, and I realize that we all sort of

19 revert to shorthand. But I think terms like "state match"

20 are not helpful, because this is not a state-matching

21 program. This is a state-run program for which states can

22 receive federal financial participation for allowable

1 expenses.

2 And so that's why I don't have the problem,
3 Penny, you did, is that what I hear being said is the state
4 match is lower than we think it is, and I guess my response
5 to that is there is no such thing as the state match. So
6 that's not the implication I want to -- what I want to work
7 from.

8 And I -- so where I go back is to, as you did,
9 bring us back to sort of the rate discussion this morning,
10 to sort of think, given these two narratives -- and I
11 completely agree, Penny, they can both be true -- there are
12 a couple of different ways to go with the implications of
13 this analysis, and I think one of them, which is an area
14 where there has been a lot of policy-making, is around the
15 federal policy response to the notion that if providers are
16 contributing money they shouldn't get it back, and you have
17 limitations on all of that. That requires a very focused
18 analysis of the financial flows. That's not an aggregate
19 analysis. That's a very targeted analysis, situation by
20 situation.

21 The other policy direction to go with these kinds
22 of analysis is the overall assessment of the financial

1 structure of the program. Should it -- should we change
2 the structure? Should we change the match, the federal
3 participation? Should we -- you know, what are the
4 implications of block-granting in terms of how it locks in
5 various things? This kind of analysis, I think, is helpful
6 for that. What I worry is it gets used for the former,
7 where you need a finer lens.
8 So what I'm trying to do, similar to this
9 morning, is think about the technical issues that need to
10 be addressed to use this the way I think you intended, but
11 to not pretend that this will ever be the right mechanism
12 for figuring out the policy response to concerns about
13 recirculating money, because that's just -- that's a whole
14 different place to go.
15 And so that brings me, again, sort of back to
16 where we were this morning, which is that, you know, I'm
17 not going to add a lot to the technical questions that
18 Penny asked, but I think -- I know you didn't say it's the
19 worst case and I agree it's not, but it does feel, to me,
20 like this does reflect sort of an upper bound of what you
21 would think of as the possibility that federal dollars are
22 flowing without the state putting in its share. My

1 problem, again, with that is that that's not how the
2 program is designed so I'm not sure I even want to use that
3 language.
4 That's my reaction to that.
5 CHAIR ROSENBAUM: Okay. Andy then Toby then
6 [inaudible].
7 COMMISSIONER COHEN: Um, fascinating. Again,
8 long-term conversation. I was surprised that the upper --
9 let's call it for the moment the sort of reasonable upper-
10 bound number was 4.7. I think that's lower than most
11 people who have been engaged and work in this program would
12 have thought over the years, so I think that's an
13 incredibly interesting finding. I share all the same
14 concerns about use of the analysis, because of the nature
15 of having to lump so many things together.
16 And I just, for purposes of illustration, just
17 want to offer the example of New York, which requires its
18 counties to make really substantial contributions towards
19 state share. It comes from tax revenues, general revenues.
20 It goes to the general pot of the state for, you know,
21 getting matching and paying providers, and it's really
22 substantial. I think New York City spends well over $5

1 billion a year of city tax levy dollars on these things.
2 So, I mean, that is not recirculated money. That is simply
3 money that has come from a different tax base -- actually
4 the same tax base; different taxing authority.
5 So, anyway, I just think that, you know, and it's
6 a huge program, and California has, I think, some similar
7 kinds of things that -- you know, and those are two of the
8 biggest programs in the country. So those, you know, those
9 facts are extremely relevant to this notion of the upper
10 bound of what we're really trying to get at, which is the
11 possibility of sort of recirculated money, and the I-know-
12 it-when-I-see-it kind of test.
13 CHAIR ROSENBAUM: Okay. Toby.
14 COMMISSIONER DOUGLAS: Just first, just to
15 understand. Technically, were those -- like what Andy
16 described -- are those included, because they are big, big
17 dollars.
18 MR. PARK: So, again, like I said, we did not try
19 to do everything at the state level. So we tried to do
20 kind of like a high-level assumption that we applied to
21 every state. So, in that case, we -- for example, for like
22 New York or California, we may have overestimated the

1 amount of money that we took out, because, you know, those
2 are examples where it's not necessarily coming from a
3 particular provider class.
4 COMMISSIONER DOUGLAS: Yeah. I mean, I think one
5 thing -- and this gets to the buckets of CPE versus IGT and
6 provider taxes -- the CPE -- you know, there was a way -- I
7 mean, that is, as Penny said, a cost. And so there's a way
8 to, you know, look at that separately.
9 MR. PARK: Yeah. So we --
10 COMMISSIONER DOUGLAS: No, no. Go ahead.
11 MR. PARK: Oh. So I was going to say we did
12 assume that a lower -- we did remove a lower percentage
13 from CPEs than we did for provider taxes or IGTs.
14 COMMISSIONER DOUGLAS: Okay. Okay.
15 And then, I mean, I don't want to say a lot.
16 One, the same, this is such an important area. I do get
17 very concerned of how it's going to be used, and, you know,
18 and not critiquing -- just the word "value" really scares
19 me, because a delivery system, regardless of how the
20 payment, it's still essential to the system that they have
21 today. And so any discussions about this, when you're
22 talking now in the context of changing the financing, has

1 to start with, this is the states -- both of those
2 statements are true. They've been using permissible ways
3 to fund the program and yet it is true that it can be
4 viewed as distorting the federal-state ratio.
5 And so we now need to look at financing from that
6 starting point if we're going to make any changes, that
7 this is important funds within the system that are
8 stabilizing the delivery system and any changes can't just
9 suddenly take those away.
10 CHAIR ROSENBAUM: We have Stacey and then Marsha.
11 COMMISSIONER LAMPKIN: So this has been so
12 educational for me to hear how other people think about
13 this, so I really appreciate that.
14 With respect to the netting question, I think
15 it's very understandable from a more layperson like me,
16 with less regulatory background, to understand how this
17 feels like a relevant question. And so we really do have -
18 - it seems like we can't ignore it but we just have to be
19 very careful about how we talk about it, and perhaps put
20 some illustrative examples around to help people with their
21 thinking.
22 And I think of a couple of hypothetical examples

1 that have nothing to do with supplemental -- fee-for-
2 service supplemental payments but in a budget constraint
3 situation. So you might have an example of a hospital tax
4 being implemented or being raised to help mitigate the
5 effects of a budget cut, but it's a broad-based hospital
6 tax. And so that's one example of a technique that maybe
7 feels like less important to net out of a calculation as
8 contrasted with another one where we've got a budget
9 situation, and now if there are hospitals who have access
10 to IGTs and want to buy back their cut, they can do that.
11 But other hospitals without access to something
12 cannot, and then you introduce a different kind of dynamic
13 there where if the service would be provided anyway, absent
14 the extra money coming in, it feels like there is a federal
15 share consequence that may be, not technically, a state
16 match question, or it's still an expenditure, but there's
17 something there, whatever you call it.
18 So I don't know how we talk about this in the
19 more nuanced way. Because of these kinds of nuances I
20 would be leery of the calculations just in understanding
21 kind of the broad-swath assumptions that had to be made.
22 It seems like, though, with those examples, that

1 these are areas that CMS has the ability to monitor through
2 reimbursement methodology and its effects on access. So if
3 they see a situation where the reimbursement methodology is
4 producing access issues or disparities from one hospital to
5 another that don't make sense, that there's already a
6 mechanism to monitor and kind of keep a lid on that. Is
7 that fair?

8 COMMISSIONER THOMPSON: Well, I'll just jump in
9 to answer that question. I think there are guardrails but
10 they aren't necessarily individual judgments. So you have
11 a -- you know, you have a guardrail around the UPL, which
12 we've discussed here, which is, are the total expenditures
13 to that class of providers reasonable, without necessarily
14 saying every individual rate paid for every individual
15 service to every individual provider in that class are what
16 we would judge as reasonable. There's requirements for
17 developing and publishing rate methodologies, but again,
18 that doesn't always talk about what the actual expenditure
19 arising out of that methodology will be. And then there's
20 requirements to provide access.

21 So there's sort of a whole bunch of things that
22 kind of circle around it, without trying to get the federal

1 government into the business of approving individual rates.

2 CHAIR ROSENBAUM: Marsha.

3 VICE CHAIR GOLD: Yeah. Some of -- if some of my

4 question is because I don't understand the accounting terms

5 there, please correct me, because I don't -- I mean, I'm

6 not an expert on all those accounting terms that you're

7 lumping together here.

8 Here's what I'm concerned about. Just like in

9 the federal government you have the states, as to what the

10 role of federal government and the state should be. In

11 fact, it's not what the federal government or the states --

12 it's that the states also have very complex relationships

13 with their localities and cities, and they could even

14 differ within the same state for the big cities versus the

15 counties. Some of those are laid out in constitutions,

16 they're part of state law. All those things affect who's

17 responsible for health care, and who's responsible for

18 financing health care, and I think it's why, in states like

19 New York, the counties pay half -- or certain counties pay

20 half of the state match, or whatever the right answer is to

21 that, and in some other places it's there.

22 And to my mind, I don't know why we're even

1 looking at that. That's a function of state and federal
2 relations that's defined by law. What I thought we were
3 looking at is sort of payments that we think may have maybe
4 sort of going in many directions at once in different ways.
5 And so I'm still concerned that while we're
6 trying to look at provider payments, we're lumping it
7 together with stuff that I think is just statute and part
8 of practice, if, in fact, we're doing that, and I would
9 prefer that we separate that out or leave it out, whichever
10 you care, but not mix it together, because it's -- we could
11 have a debate. I personally think there's more of an issue
12 of provider payments that go back to providers than
13 worrying about how the states and localities divide their
14 financial responsibilities for paying for Medicaid.
15 CHAIR ROSENBAUM: Let me just follow up on that,
16 and your point was very well taken, and Alan's earlier
17 point.
18 What we have going on here -- let's park this
19 morning's discussion on how providers get paid. This part
20 of the discussion is really a fundamental -- the
21 fundamental tension between tax law and public welfare law.
22 Okay. From a public welfare law perspective, Medicaid

1 says, as Alan pointed out, and literally this is how the
2 program works, that if a state spends money, the federal
3 government contributes according to a formula for approved
4 expenditures. The operative word is "spend." Okay, what
5 does it mean to spend?

6 And federal Medicaid law has taken, historically,
7 because it was built on all of the medical indigent
8 programs that came before it, took a very generous view of
9 what it means to spend. You could spend by spending cash.
10 You could spend by foregoing revenue that you might
11 otherwise collect, that your locality spent on indigent
12 care programs. You could spend by supporting public
13 hospitals in the state.

14 Over the years, we've gotten a little more
15 refined in the word "spend," and so we have certain ground
16 rules for, you know, when we count something as an
17 expenditure and when we don't, for federal contribution
18 purposes. But if you put on sort of your tax law hat, and
19 this issue of the constitutional relationship between state
20 and federal governments, it is a tremendously substantial
21 leap to have the federal government say to a state, beyond
22 certain modest things like, you know, we want to see that

1 you actually have a tax coming in, that there's really
2 money in a tax scheme coming in, for the federal government
3 to say if you don't follow our kind of taxation
4 arrangements for your Medicaid program we won't match it.
5 If you said no more local spending on Medicaid
6 you're essentially saying to state, you must impose a
7 state-level tax and not just have revenues foregone that
8 are the result of a local taxing base. You know, if we
9 don't allow any more taxes on, essentially, the sale of
10 hospital services to the state, or to private insurers in
11 the state, you know, if you use that kind of a tax we won't
12 recognize Medicaid spending anymore.
13 I mean, in other words, there comes a point at
14 which not just politically but also as a legal and
15 constitutional matter we find ourselves in uncharted waters
16 and I think we find ourselves on issues -- in the middle of
17 issues that are so extraordinary issues, quite frankly,
18 compared to anything that's come before, compared to a UPL
19 payment rule, or a provider tax rule, that I think -- I
20 feel, personally, that our better focus is on what do
21 states do. How do states invest the money that they
22 generate through their spending arrangements that are

1 approved under law, and are there more effective and
2 efficient ways that we might think of in making
3 recommendations to Congress? But in terms of fundamentally
4 altering the federal-state relationship over tax policy is,
5 to me -- you know, we are venturing into an area that we
6 are not really equipped to deliberate.
7 I mean, for starters, I would want to know how
8 all social welfare spending happens in states. I would
9 assume that states diversify their revenues for all kinds
10 of programs--education spending, social service spending,
11 correctional institution spending, highway spending. I
12 mean, you name it. States come up with all kinds of ways
13 to generate the revenues they need, and that is an area of
14 great, you know, policy import to a state. I think that
15 Medicaid can lay some ground rules about when, you know, we
16 count state expenditures and when we don't, but I'm not
17 sure that we want to be recommending these issues that I
18 think sort of fall into tax policy as much as they do
19 health policy.
20 And I think it's reinforced, sitting here and
21 listening to this, it's reinforced, for me, by the fact
22 that we're working at a high level, so we can't really

1 follow the trail of funds. We don't see any evidence that
2 there's a -- you know, a direct correlation between the
3 taxes you pay and the rates that are set and the money you
4 get back. And, in fact, federal law prohibits that.
5 So what I do think we need to be concerned about
6 are, you know, are rates being set for programs in ways
7 that generate efficiency and quality of care, or other
8 things that we might worry about. But this is a huge
9 issue.
10 COMMISSIONER THOMPSON: Yeah, just to follow on
11 that point. So I just wanted to come back around then to
12 some of the questions about what are we doing with this and
13 where are we going with it. I've been, you know,
14 consistent in saying I'm more interested about the
15 expenditure side of the equation for some of the same
16 reasons that Sara and Marsha have talked about, which is,
17 you know, a little bit of -- the concern around the
18 provider contributions and kind of where I was going
19 initially with our calculation and representation is a
20 little bit of the idea that a provider is making a
21 contribution, the state is using that to generate an
22 expenditure for which there is a match, that ultimately

1 ends up in the hands of the provider that initiated the
2 transaction to begin with, and in the end that the provider
3 is out nothing, the state is out nothing, and it is the
4 federal government that is paying whatever is being paid,
5 which means -- and this is where, Anne, I was going
6 originally with by definition -- that nothing happened that
7 was really worth that initial state expenditure, which
8 means it didn't really produce value to the program.
9 So I'm more interested in ultimately those issues
10 present themselves because it's an unusual circumstance. I
11 mean, it's not unusual for a state to, for example, raise
12 revenue from a regulated industry, to regulate that
13 industry. What is a little different here is that you have
14 a group of providers, let's say, who are actually
15 delivering services and who are actually the engine by
16 which the program operates, and they are contributing funds
17 that ultimately get put together with federal dollars to
18 pay them for the services that they provide. And the
19 skepticism from some people comes in the entanglement
20 between those two sides.
21 I think it's more easily analyzed, though, by
22 looking at the expenditure side of the equation, which is

1 where are the expenditures being made and on what basis and
2 for what services and outcomes and values for the Medicaid
3 program. And, again, we come back to the age-old
4 supplemental payment issue of trying to understand
5 supplemental payments, where they're going, what they're
6 buying, and what they're generating in terms of goods and
7 services for the Medicaid program.
8 There's been various proposals that people have
9 made over the years about -- you know, GAO has been active
10 in this area for a number of years making -- and the
11 Inspector General's office at HHS -- making arguments that
12 I haven't been supportive of, for example, about limiting
13 public hospitals to cost, mostly just because I think that
14 we should be promoting value, and sort of going backwards
15 to kind of cost-based systems doesn't seem like the right
16 direction to me. People have talked about kind of
17 provider-level UPLs, which I don't know if they're really
18 workable or not workable, heightened scrutiny or
19 transparency around the supplemental payments and where
20 they're going and what they're doing and better reporting
21 and all of those kinds of things, and maybe some changes
22 around what states have to do in terms of combining all

1 sources of payments to providers or generating certain
2 kinds of financial reports that would help provide some
3 insight into this.
4 I think that kind of culling through those
5 questions and thinking about whether those particular kinds
6 of recommendations are ones that we would want to support,
7 as well as others that we could come up with, I think
8 putting some effort into that payment and expenditure side
9 for how do you -- which is -- this is a very difficult
10 question. How do you decide that a set of payments made to
11 a provider are efficient and effective? We saw earlier the
12 variation among the states, and payment methodologies and
13 total dollars and how we calculate that. So this is not
14 for the faint of heart. But I do think that it is kind of
15 ultimately the question, that if you have something that
16 you're paying that's producing value and goods and services
17 that you want to recognize, then the source of the funds
18 that contributed to the state expenditure are less
19 relevant.
20 EXECUTIVE DIRECTOR SCHWARTZ: I'm going to push
21 back a little bit because I think we need -- the staff need
22 help in figuring out what the next step is, because I'm

1 trying to think, Penny, about if we want to get where
2 you're talking about, what would be some of the
3 intermediate things that we could do that would help
4 eliminate those questions for you. And I'm having a hard
5 time trying to think about what's the analysis that we
6 could do of -- given the data we have, having already noted
7 the many limitations, particularly on the provider level,
8 what kind of analysis do you think would be compelling to
9 help us figure that out? Because we can -- I mean, we can
10 look at expenditures across states, you know, per person.
11 We can look at certain types of services. I don't think we
12 have a good benchmark to judge, you know, sort of the
13 correlation between supplemental payment and, like, were
14 those services good services or not good services, or, you
15 know, is the level of payment too high because we can't
16 really get at that?
17 So I'm just trying to -- I'm kind of grasping at
18 straws here about like what --
19 CHAIR ROSENBAUM: Where should you go.
20 EXECUTIVE DIRECTOR SCHWARTZ: Yeah, what could we
21 do specifically -- like what data would you find compelling
22 to help us move to the next step? Because that's what we

1 really need help on so we can have the conversation --

2 VICE CHAIR GOLD: Where are we trying to get to,

3 Anne? I think part of this may be a lack of clarity on the

4 Commission side as to what the purpose of this analysis is.

5 COMMISSIONER LAMPKIN: And I would say I think

6 it's a hard question for me to answer, is what is the next

7 analytic step, because I don't feel like we've had enough

8 discussion about what we think and where we think the

9 opportunities are. For me personally, my concern around

10 this is less around recycling money kinds of increased FMAP

11 implications, as much as the disincentives that this very

12 allowable funding approach presents in delivery system

13 reform. I mean, that's where my burn is, honestly. If

14 we're interested in aligning financial incentives and

15 buying quality and outcomes, if we have an environment

16 where particular provider types' expectation is that a

17 certain volume of dollars comes back to it because of a tax

18 structure or because of a funding structure, that limits

19 your ability to rebalance where services are coming from in

20 your system and drive to value.

21 So what kind of policy options might there be if

22 we live with these funding sources to address on the policy

1 side as a way to improve that dynamic?
2 CHAIR ROSENBAUM: Yes, another way of maybe
3 saying it is given the nature of the inherent structure of
4 the federal-state Medicaid financing relationship, what
5 types of standards would you want related to delivery
6 system reform, I mean, I think that some of the 1115 work
7 that the administration has carried out over the past
8 several years under the wonderful acronym DSRIP -- one of
9 the worst I've ever heard. But I think that some of that
10 is the beginning of an effort to try and deal with this
11 question. You know, given our relationship, given the fact
12 that there are two partners at the table, what kinds of
13 indicators of quality or value or performance or whatever
14 you want to say might Congress begin to think about, might
15 the Secretary begin to think about, given the financing
16 arrangements. And the natural tendency of those financing
17 arrangements may be to pull in a direction away from a
18 value-based purchasing system. What would be some
19 countervailing steps that we might think about? And there,
20 you know, it seems to me there's a fair amount going on in
21 the world of demonstration programs, other programs,
22 managed care programs, for how we are beginning to

1 articulate value in payment so that we might go down that
2 avenue and come up with some indicators as opposed to sort
3 of trying to deconstruct it from the financing perspective.
4 COMMISSIONER COHEN: I think I had an earlier
5 point. I will combine it with the later thought that just
6 came to me. I just think very worth noting a point in here
7 that almost -- much of this additional contribution, not
8 from state general revenues or whatever, is hospital
9 related. Again, another potential sort of distortion with
10 where we want the delivery system really to go. And I
11 would say one thing that we could talk about, think about,
12 explore, is around the managed care and supplemental
13 payment connection, because it is a terrible disincentive
14 for states to move away from fee-for-service payment when
15 they lose UPL and other kinds of supplemental payments, and
16 to figure out a way to say you've got a baseline, let's
17 think about that baseline and how to get more value out of
18 it rather than you want to do value-based payment and you
19 lose your access to something that you as a state have
20 depended on for a very long time.
21 CHAIR ROSENBAUM: Well, it's built into the
22 taxing scheme of the state. It's part of its DNA. And I

1 think that, you know, it seems to be echoed somewhat around
2 the table that the real focus of the work is how do you,
3 given the financial relationship between the federal and
4 state governments and the inherent directions in which that
5 relationship can pull at the local service delivery level,
6 how do you build the system that can overcome some of those
7 natural tendencies? What kinds of performance measurement
8 structures do you use? What kinds of emphasis do you put
9 on your payment structures? So sort of taking the
10 situation from a revenue side as it lives and thinking
11 about what you do with it then.
12 Just to try and come back -- I really don't want
13 to leave Anne hanging like this, and I don't want to leave
14 staff hanging like this. I think what we're saying is that
15 if we take -- and please jump in and help me here. I think
16 if we take the three presentations we've heard now, you
17 know, how -- I'm going to put the DSH issue aside, because
18 I think that is a discrete activity that we can come back
19 to. So if we think about hospital supplemental payments
20 and then bookend it by the federal-state financial
21 relationship, we're saying -- I think the emerging sense of
22 the Commission is that, to the extent that the morning and

1 the afternoon presentations draw a link, our sense -- and I
2 think we couldn't have gotten there without the
3 presentation and without all the work that came leading up
4 to this. But our sense is that linking the two discussions
5 and essentially trying to offer solutions on both sides of
6 the equation is not where we think the value of our
7 contribution lies.
8 Where the value of our contribution lies is going
9 back to essentially this morning's discussion about
10 supplemental payment policy and realizing that there's a
11 lot we don't know, so we may want to try and come up with
12 an agenda that refines our knowledge about supplemental
13 payments and what happens with them and where they go and
14 what they do and how they're faring in a new world where
15 we're moving more and more toward, you know, a capitation
16 system that doesn't include supplemental payments. And
17 that what we really want to focus on is how you could
18 construct a policy that ensures that wherever states are
19 setting their payment rules -- which they may do for all
20 kinds of reasons, and they have a fair amount of autonomy
21 in the statute to do so -- that the states are selecting
22 from sort of a series of options that, in our view, get us

1 toward something that we loosely put under the banner of
2 value. In other words, that there is a direction we're all
3 moving and you're not just making payments to a provider to
4 make payments to a provider because the provider's always
5 been there. You're making payments to the provider in
6 order to strengthen its performance for the people it
7 serves.

8 And so that I think is where we want to be in
9 this vector here and not -- we want to be on the morning
10 side of the discussion and less on the afternoon side of
11 the discussion, where I think we're dealing more with
12 historic questions of taxation policy and federalism that
13 are tangentially related to Medicaid, but they're related
14 to every other social welfare question we could ask.

15 COMMISSIONER COHEN: I would just add to that, I
16 actually thought that was a really good summary, and I
17 think that orientation to start thinking about like what is
18 everything that we can do as a Commission, to start
19 thinking about every -- you know, every dollar having some
20 sort of value connection, and how you sort of get from
21 where you are now to there is a good direction.

22 I would also say every single conversation today

1 has centered around how impossible it is to have a policy
2 discussion -- and we're not supposed to be having an
3 enforcement discussion here. We're supposed to be having a
4 policy discussion without information about provider-level
5 supplemental payments. But we've made the recommendation
6 before, but all of this comes back to that point. It is
7 really hard to move forward in policy on these questions
8 the way they're framed without that information, so just
9 more emphasis on the need for that if you want to have a
10 policy discussion about supplemental payment. The
11 direction and how you execute on that direction to try and
12 think about ways to make supplemental payments more value-
13 oriented I think is the right one -- is the right question,
14 but what are the analytic steps for the sort of policy
15 directions that we can go on, I think we all need to
16 brainstorm a little bit more.
17 COMMISSIONER DOUGLAS: So I don't want to be the
18 naysayer. I completely agree on the fact that these
19 supplemental payments have caused havoc with driving value.
20 That being said, if too much of the focus is on just the
21 value side, the entity -- seeing this, you know, on a state
22 level, the entities that have been funding -- or have been

1 putting up the dollars might just not do it. And so you
2 have a very tenuous situation here which gets back to the
3 financing of, you know, whether it's an effective FMAP of
4 whatever it was, 57 or 60, you know, whatever that is,
5 you're not dealing with that fact.

6 And so just focusing on value, the providers,
7 some of whom, you know, you're relying on to make this
8 work, have very little focus on Medicaid, are going to walk
9 away and the whole thing crumbles.

10 So we can't forget that. I'm not saying that we
11 can't focus on this, but we at some point need to come back
12 to the underlying financing and why it's been structured
13 like this at a state level and why they've had to do this
14 and why providers have been willing to step up. And if we
15 don't keep that in mind, then value will be all for naught.

16 CHAIR ROSENBAUM: Well, for sure it's a very -- I
17 mean, just as there are federal and state partners, you
18 then end up with state and locality partners.

19 I have to say one of my reactions to today was
20 that I don't think that the word "contribution" is the
21 right word. There is the taxation or there's an
22 intergovernmental transfer. It is not a contribution the

1 way, you know, you make a donation. It is discretionary to
2 a degree because a local entity, a local government could
3 decide to alter its taxation base and announce it's not
4 going to generate the local revenue, although I presume
5 state law, you know, might require it. And you certainly
6 could have providers resist a broad-based provider tax.
7 Now, I'm never quite sure what it is when it's a
8 public hospital district, whether at that point it's an IGT
9 or a tax. But be that as it may, I think you drive home
10 the point that what makes Medicaid so complicated is that
11 it's a cascade of complicated relationships. It is this
12 incredibly delicate balance at one level between the
13 federal and state governments, at another level between
14 states and their localities, states and their health care
15 providers. And how much you can incentivize Medicaid to
16 alter itself is certainly a question, but I will tell you,
17 I was just saying this to somebody the other day, when I
18 look at Medicaid 20 years ago and I look at Medicaid today,
19 it's dramatically different programs.
20 And so I think change comes, and it comes very
21 slowly, and part of it is because there's so much
22 collateral damage that could happen along the way. I think

1 we actually have a lot to learn from the DSRIP and 1115
2 demonstrations that are trying to do this. And that's, you
3 know, a useful thing for us to plumb. And, clearly, it
4 would be nice to know more about exactly how supplemental
5 payments are put to work at a provider level, which we may
6 or may not ever know.
7 We have time for public comment.
8 **### PUBLIC COMMENT**
9 * [No response.]
10 EXECUTIVE DIRECTOR SCHWARTZ: Nobody else has
11 figured it out.
12 [Laughter.]
13 CHAIR ROSENBAUM: People are, like, "Ohh." When
14 I looked at this agenda the other day, I said this is going
15 to be a tough day.
16 Okay. Well, we are now on break.
17 * [Recess.]
18 CHAIR ROSENBAUM: All righty. We are coming down
19 the home stretch here, and, of course, we've saved the best
20 for last. We are up to Tab 7 now, which is the review of
21 children's coverage recommendation papers, and Joanne will
22 present an overview for us so that we can basically give

1 the MACPAC staff our feedback on what we'd like to see
2 brought forward to us in December for what we anticipate
3 will be a formal committee vote.
4 So, just to remind everybody, we are not voting
5 today. The voting meeting is December. What we are doing
6 today is expressing our preferences regarding what we'd
7 like to see brought to us in December, based on all of the
8 discussions we've had over the year or so.

9 **### REVIEW OF CHILDREN'S COVERAGE RECOMMENDATION**
10 **PACKAGE: DRAFT SPECIFICATIONS**

11 * MS. JEE: Okay. So this afternoon, we're
12 returning to the Commission's work on children's coverage,
13 really picking up where you all left off at the May
14 meeting, and you will recall that in May, the discussion
15 focused on some key components for a recommendation and
16 several related decision points therein.
17 In May and in earlier months, your discussions
18 have highlighted that any recommendation on children's
19 coverage should address both the short-term issues for
20 states and children by extending CHIP, but also a movement
21 toward a longer-term vision in which there is a more
22 seamless system of coverage for children and to provide

1 states with some options for doing that.

2 At the end of the May meeting, Commissioners, you
3 asked staff to come back with you to today's meeting with a
4 straw man proposal or something that we're also calling
5 "draft specifications" that are built around the inputs
6 that you've provided.

7 So, today, we are going to review with you the
8 staff straw man, which includes four elements, and we
9 really look forward to your comments and inputs onto each
10 of those elements. So, based on your conversations, staff
11 thought that you really seemed to coalesce around four key
12 areas. The first is extending CHIP funding; the second,
13 permitting optional CHIP-funded exchange subsidies. The
14 third is broadening state innovation waivers, and the
15 fourth is extending the expiring provisions that often ride
16 along with CHIP.

17 During the presentation, I am going to focus
18 really on the design specifications for these elements, but
19 your meeting materials include some of the rationale that
20 go beyond that, and, of course, those are very important.
21 If you have comments on the elements and the specs
22 themselves as well as the rationale, we'd appreciate

1 hearing from you on those today. And this is really just
2 our best attempt to capture what we think we've heard you
3 say so far.
4 After going over the recommendation straw man or
5 the draft specs, we're going to talk very quickly about
6 what the next steps are.
7 So the first element is really the foundation of
8 the recommendations package, and that's an extension of
9 CHIP funding. Commissioners, you've discussed extending
10 funding anywhere between two and ten years, but you really
11 seem to coalesce around something in the middle. So the
12 straw man has a CHIP funding extension for five years,
13 which is essentially the midpoint.
14 Moving on to the maintenance of effort, the
15 strawman maintains current law, and that permits the
16 maintenance of effort to expire after fiscal year 2019.
17 Based on your conversation regarding the MOE, we think this
18 is where you are headed over the course of your
19 discussions.
20 Moving on to the next part, which is the CHIP
21 matching rate, you have previously discussed the 23
22 percentage point differential to the CHIP-enhanced match,

1 and that it doesn't really relate to any increased
2 enrollment in children's coverage or any improvements to
3 that coverage, but that it does cause the states to spend
4 down their allotments more quickly.
5 You've also noted that states would face some
6 difficulty if that CHIP matching rate and that differential
7 were to change suddenly.
8 So the draft specifications include a phase-out
9 of the 23 percentage point differential and the CHIP
10 matching rate by fiscal year 2020.
11 Your materials lay out an example of how a phase-
12 out might work, so your reactions to that would also be
13 useful.
14 And, finally, also related to the CHIP matching
15 rate, the draft specs include one more item, and that is
16 adding a 5 percentage point differential to the enhanced
17 CHIP match rate for states with CHIP eligibility at or
18 above 250 percent of the federal poverty level.
19 In past meetings, Commissioners, you have
20 discussed that children around this income range experience
21 vulnerabilities to lack of coverage or high out-of-pocket
22 cost, similar to children with lower income.

1 The second element is optional CHIP-funded
2 exchange subsidies. This element would give states a new
3 option for using CHIP funds to help CHIP-eligible children
4 purchase exchange coverage. There is an important decision
5 point for you here that relates to the federal exchange
6 subsidies, but I am going to come back to that after I lay
7 out the rest of the framework for this option.
8 On eligibility, states would determine
9 eligibility up to their CHIP income eligibility levels, and
10 on affordability, this is something that, Commissioners,
11 you have talked extensively about. And given the concerns
12 related to affordability of coverage on the exchange, the
13 draft specifications would apply the CHIP standard that
14 limits family out-of-pocket spending for premiums and cost
15 sharing to 5 percent of family income, and the draft
16 specifications would also require that the exchange plans
17 purchased with the CHIP subsidies have an actuarial value
18 that is substantially similar to CHIP, which is on average
19 about 98 percent.
20 On benefits, the draft specifications lay out
21 that states taking up this option would need to ensure that
22 children are provided benefits that meet the state CHIP

1 coverage levels, and that would include oral health
2 services.
3 Commissioners, you have talked a lot about cost
4 effectiveness in the context of CHIP and Medicaid. You
5 have noted the difficulty that states have experiences with
6 the cost-effectiveness test. So the draft specs focus on
7 ensuring that the states' approach to using these subsidies
8 would promote efficiency and children's coverage.
9 The draft specifications also propose a
10 requirement that states provide public notice and an
11 opportunity for stakeholder comment prior to their
12 submitting a state plan amendment to CMS.
13 And, finally, the straw man calls for a
14 secretarial evaluation of the subsidies to shed light on
15 the impact of these subsidies on things such as coverage,
16 access to care, affordability, and network adequacy.
17 So here is where I wanted to return to that
18 decision point that I provided to you a couple of slides
19 ago, and the question before you is whether CHIP-eligible
20 children who would receive the CHIP-financed exchange
21 subsidies, whether they would also receive the federal
22 exchange subsidies for premiums and cost sharing, so in

1 addition to those subsidies, or if they would get the CHI-
2 financed subsidies without the federal exchange subsidies.
3 As a reminder, individuals with incomes between
4 100 to 400 percent of federal poverty, of the federal
5 poverty level, are eligible for the federal premium
6 subsidies on the exchange and those with incomes between
7 100 and 250 percent of the FPL are eligible for cost-
8 sharing subsidies if they purchase a Silver Level Plan.
9 If the CHIP subsidies are provided in addition to
10 the federal exchange subsidies, the federal subsidies would
11 be based on the current exchange rules. The CHIP subsidies
12 would pay for the child's portion of the exchange premium.
13 CHIP subsidies would also be used to provide
14 wraparound. Remember we talked about applying the CHIP-
15 level protections. So it would be used to provide any
16 wraparound on cost sharing and to help bring the exchange
17 plan AV level up to the CHIP level.
18 I do want to note that under this option, state
19 CHIP spending would be reduced significantly, and federal
20 spending would be increased. And it also would be more
21 complex to administer relative to the option in which the
22 CHIP subsidies are provided without the exchange subsidies.

1 And, if the CHIP subsidies are provided without
2 the exchange subsidies, the CHIP funds would also be used
3 to provide any needed wraparound coverage.
4 CHAIR ROSENBAUM: Just to clarify, within this
5 option, we have a choice to make --
6 MS. JEE: Yes.
7 CHAIR ROSENBAUM: -- about whether to recommend at
8 some point maybe a financing arrangement that would
9 essentially -- I hate the word, but I'll use it -- "blend"
10 the federal premium tax credits with the increment, the
11 increment to bring everything up to CHIP levels, coming out
12 of state CHIP funds, or to allow the option to essentially
13 merge a market, but using only state CHIP funds to do it.
14 MS. JEE: Right. So, in the first option, there
15 is the federal subsidy and a CHIP subsidy, and in the
16 second option, it's just the CHIP subsidy.
17 CHAIR ROSENBAUM: And I should just note -- and
18 we'll talk about this more, I know -- that even simply
19 allowing the states to merge their markets and buy exchange
20 plans using CHIP funds is an important policy discussion
21 because the rules for exchange plans and CHIP plans are not
22 exactly the same.

1 MS. JEE: Right. So that's perhaps the first-
2 order question.
3 CHAIR ROSENBAUM: Right, exactly.
4 MS. JEE: Okay. So, moving on to the next
5 element of the straw man, which is broadening state
6 innovation waivers, Commissioners, you've talked a lot
7 about a longer-term vision for children's coverage, and the
8 hallmark of that would be greater seamlessness across those
9 sources of coverage, particularly with respect to
10 affordability and benefits.
11 A new optional waiver would provide an
12 opportunity for states to take some steps toward that
13 vision and would support their efforts to integrate
14 Medicaid, CHIP, and exchange coverage for states that would
15 want to do that. Again, this would be an option.
16 The draft specifications or the straw man would
17 also direct the Secretary of HHS to establish some state
18 participation criteria to identify states that could
19 participate in this, as well as develop a waiver template
20 to help simplify the application process for states.
21 States pursuing this option would also need to
22 demonstrate that their waivers would not result in losses

1 of children's coverage rates, and for those children who
2 are under 133 percent of FPL, the Medicaid rules would
3 apply.
4 Okay. And just wrapping up with the waivers,
5 federal funding for the waivers would come from Medicaid,
6 CHIP, and exchange funds that states would have spent of
7 children's coverage, absent the waiver. And, as with the
8 subsidies, there would be a requirement for an evaluation
9 of this approach.
10 The last element of the draft specs or straw man
11 is the extension of expiring provisions that have been
12 renewed along with CHIP funding in years past. So the
13 straw man would extend through fiscal year 2022. Authority
14 for states to use express line eligibility to determine
15 eligibility for children in Medicaid and CHIP; would extend
16 funding for outreach and enrollment grants; and would
17 extend funding for the Pediatric Quality Measures Program
18 as well as for childhood obesity demonstration projects.
19 The expiring provisions is the last of the four
20 elements of the straw man that we have developed for you.
21 Before we move on to the slide on next steps, I just wanted
22 to let you know that we did receive a preliminary cost

1 estimate on the package, and that estimate has the entire
2 package coming in at about -- as increasing federal
3 spending by about 3.4- to $3.7 billion over five years, so
4 that would be the range.
5 And a couple caveats that are important to that
6 cost estimate, first is that the estimates would really
7 depend on -- could be affected by whatever legislative
8 language is ultimately developed by the Congress around any
9 funding of CHIP, and a second caveat is that the estimate
10 does not account for the new benefits notice and parameters
11 for 2018 issued by CMS, which includes proposed age rating
12 factors for children. And that would change premiums in
13 the exchange for children. So that is not yet factored
14 into the cost estimate, and CBO generally does not factor
15 in proposed rules. And we expect that once those rules are
16 finalized, if it retains the child age rating factors, that
17 we might see that reflected in the baseline in March.
18 Okay. So, to just quickly go over next steps,
19 based on the conversation that you all have here today,
20 staff will take your feedback and input to prepare draft
21 recommendation language for your consideration in October,
22 and that language would go over the specs as well as cover

1 the rationale. So, in October, you would review that
2 language and again provide us any feedback, and in
3 December, Commissioners will review the revised language
4 one more time and make sure that we've captured everything
5 correctly. And then we anticipate a vote at that point.
6 Following that, we would publish recommendations
7 with the accompanying rationale as well as any other text
8 needed to sort of set up the recommendation in advance of
9 the March 2017 report.
10 So that's the run-through of the specs. It's a
11 lot. If something doesn't seem quite right yet, then
12 please provide us as much specificity in your comments as
13 possible, and that will help us take the next step.
14 CHAIR ROSENBAUM: So the floor is open. Peter,
15 do you want to start us?
16 COMMISSIONER SZILAGYI: Sure.
17 CHAIR ROSENBAUM: Sheldon, did you --
18 COMMISSIONER SZILAGYI: First of all, Joanne,
19 this is an excellent summary of our May discussion, and I
20 think it really takes us to the next step. I think it
21 summarizes very well kind of the dual sort of streams that
22 we had in May, which is both to maintain a very effective

1 program and to provide states with options and flexibility
2 in the new marketplace. And we were kind of dancing around
3 both of those themes, and I think these four elements very
4 nicely both summarize our discussion and kind of bring us
5 toward a recommendation.
6 So, as you were talking, I was thinking of some
7 context. We've spent a lot of time at these sessions about
8 programs for which we have little data to evaluate. This
9 is one of those programs for which there is a lot of data.
10 It's been evaluated. It's highly effective. It's a
11 vulnerable population. It's a low-income population.
12 Studies over and over again have shown improvements in
13 access, quality, and outcomes, and that's hard to do in the
14 medical field now. So, to me, personally --
15 CHAIR ROSENBAUM: You led the way.
16 COMMISSIONER SZILAGYI: Well, many states.
17 To me, personally, reversing the gains from CHIP
18 is unacceptable, and so I think -- I love the word you
19 used, which is "foundation." To me, the bedrock of this
20 four-element specification is continuing the current CHIP
21 four, five years, and we can talk about that. But I think
22 that's sort of the foundation and the bedrock.

1 I think the staff has done outstanding studies to
2 demonstrate that currently in the exchange coverage, the
3 plans have very poor actuarial value, poor benefit
4 structure, and it won't work for children. They just won't
5 work, so we have to do something to improve that.
6 The first part, I do support extending CHIP. We
7 did talk about two to ten years, and five years seems like
8 a reasonable compromise. I would be uncomfortable going
9 below five years, and we may want to have a discussion
10 about should it be longer than five years here. I just
11 think that states need a couple years to ramp up or ramp
12 down, and sort of five years would be a minimum.
13 Having thought since May, I am worried about
14 dropping the maintenance of effort in 2019, and I
15 personally would tie that to the length of extension of
16 CHIP, but we may want to have a discussions around the
17 table about that. But my thinking now would be to continue
18 the maintenance of effort for the five years.
19 The matching rate, there wasn't great evidence to
20 show that enrollment increased because of the matching, so
21 I think this concept of sort of a step down, a phase down
22 is a reasonable approach to me.

1 And the third component under this first element
2 about adding a 5 percent sort of incentive to increase in
3 the FMAP to provide states 5 percent more if they go up to
4 at least 250 percent of the poverty level follows the data
5 very well. I mean, really, kids between 200 and 250
6 percent of the poverty level are not that different in
7 terms of their unmet needs, their needs, their diseases,
8 than kids who are lower than 200 percent. So I think 250
9 percent seems like a reasonable level. I personally might
10 have picked 300 percent, but we around the table then
11 talked about 250 to 300 percent. I'm okay with that.
12 So that's the first element, extending CHIP. The
13 second element is using CHIP funds to purchase exchange
14 coverage, and I agree with this policy option. I suspect
15 there is going to be operational challenges to doing this,
16 but I really think this heads us toward what I think many
17 people around the table are interested in, which is a long-
18 term plan in the exchange that meets the needs of the
19 children, and the CHIP plans are much closer to meeting the
20 CHIP needs of children than any current exchange option.
21
22 So I personally would favor both the federal --

1 that was the first option in which we use federal exchange
2 subsidies in addition to the CHIP subsidies. I know there
3 are administrative challenges in doing that, but I think it
4 gives states the option. We may see great creativity
5 coming out of states, and I would favor that.
6 And, by the way, the cost estimates weren't that
7 high. For a large population, the 3.4- to $3.7 billion was
8 not per year. It was over five years, so $600 million per
9 year for a very large population does not seem that high to
10 me.
11 The third component broadened -- is the
12 innovation waivers, which I think is very important. I
13 won't talk about it, but I think it's really very
14 important. And I really like how you didn't limit
15 suggesting a certain number of states or anything like
16 that. We left it open, and I would favor that.
17 And the fourth option, which is to extend the
18 specific provisions -- there's actually very good evidence
19 that express lane works and that outreach works to increase
20 enrollment. So those are very evidence-based.
21 And then the other components are quality
22 measures, and I would support that too.

1 So, overall, I think it's a really good summary.
2 I think it's a really good summary. I think it will lead
3 us to a recommendation. The bedrock of this is to extend
4 CHIP for, I would say, at least five years.
5 CHAIR ROSENBAUM: Before I call on Andy and
6 Gustavo and anybody else who has a comment to make, Joanne,
7 just because not everybody who is on the Commission
8 necessarily thinks about child health all the time, can you
9 just remind people what the maintenance of effort provision
10 requires?
11 MS. JEE: So the maintenance of effort provision
12 requires states to maintain their children's eligibility
13 levels in Medicaid and CHIP at the levels that they had at
14 the time of the ACA passage through fiscal year 2019. So
15 states can't reduce their eligibility. So, if I'm a state
16 and I have my CHIP eligibility level at 200 percent, I may
17 not reduce my eligibility level to 150 or 185.
18 CHAIR ROSENBAUM: And if you had Medicaid up to,
19 say, 150 and CHIP then another 100 percentage points over
20 that, you can go higher, certainly, but you can't go lower
21 on either side?
22 MS. JEE: Yes. Yes.

1 CHAIR ROSENBAUM: Andy.

2 COMMISSIONER COHEN: Thanks so much, Joanne.
3 This has been a marathon, not a sprint, and you've been
4 terrific. And your analysis and your ability to sort of
5 move us to the next level at each phase has been very
6 impressive, so thank you.

7 A couple of big-picture points, and I'll sort of
8 go at it in the same way that Peter did first. In terms of
9 the justification and the big picture, I just don't want to
10 give short shrift to like the really big picture here,
11 which is we as a Commission, just like Congress did in the
12 1990s did when it created CHIP, are making a statement that
13 children's coverage should be different than adult
14 coverage, that there is a need for different ways of
15 thinking about cost sharing, because children don't work
16 and families have more than one child. And for all sorts
17 of reasons, cost sharing might need a different kind of
18 look.

19 So much of children's health care is about -- not
20 about they're not a high-cost population. It's about
21 prevention, prevention, prevention, and is so critical, and
22 that also tends to be somewhat different than where we are

1 with adults where a lot of sort of the bread and butter of
2 health care is around chronic care disease management.
3 This is about prevention, and we have made some statements
4 about not going backwards with respect to coverage.
5 So I think that really needs to -- children are
6 different from adults in terms of their needs, in terms of
7 the commitments that Congress has made to them a long time
8 ago, and I think we are sort of saying something about that
9 too. So I don't want to lose that in our justification.
10 We are sort of going out there with they are different.
11 So I am also comfortable with the five-year
12 extension. I think five years is a reasonable amount of
13 time and a very fair place to land between two and ten
14 years, and I think based on our past recommendation, we now
15 have some more understanding that these are major programs
16 and major decisions in a health care system that is very
17 much in flux. And nothing is going to change in two years,
18 and yet we want to set a course and a direction, so I like
19 five very much, and I'm very comfortable with that.
20 Like Peter, coming back to our big picture, I
21 have some discomfort around dropping the maintenance of
22 effort, and that may have cost implications. I have no

1 idea what kind of assumptions CBO makes about that, but if
2 one of our principles is to not go backward with respect to
3 children's coverage -- and, presumably, the MOE was created
4 in the first place -- it was such a long one, a nine-year
5 MOE. That's a long time. It really went a lot to there
6 was going to be a lot of uncertainty and need for a period
7 of stabilization after a major reform, before it was going
8 to make sense for some of these issues to be reevaluated.
9 And I think we are still in a period of substantial
10 inability with respect to the implementation of the ACA and
11 what the markets look like, and I think this would be a
12 difficult time to move back on the maintenance of effort,
13 especially in the context of this commitment about not
14 wanting to go substantially backwards for kids.
15 And I don't think it is -- I mean, children are -
16 - CHIP is not a terribly expensive program for states,
17 certainly not compared to some other health care programs,
18 and I just think it is not a huge burden on them. But I
19 know it's a very controversial point, and we will discuss
20 it, but I have become increasingly uncomfortable about
21 that.
22 Everything else, I would say I either agree with

1 Peter or agree with what's in the draft.

2 I want to get to the issue around the subsidies,
3 the CHIP-financed subsidies, the option for states, and,
4 again, we spent a lot of time trying to get our heads
5 around what this option is going to look like, but I just
6 want to put it in context. The big picture here is we're
7 saying that CHIP should be extended for five years. We
8 want to set a course and a direction for where we think
9 CHIP might go and start by providing states with an option
10 to go there on their own if they're interested. It's taken
11 a lot of our mental time space and analysis, but it is just
12 an option.

13 I don't think the question is really the right
14 question of whether or not there should be CHIP and federal
15 subsidies sort of blended or combined or not. I think the
16 answer -- the question should be around how much money do
17 you need to provide the kind of subsidies that we think we
18 need to get children's coverage to the level that we want
19 to in the exchange, and then what should the contribution
20 of sort of the state and federal government as compared to
21 where they are today are. And I don't think we have the
22 analysis to answer that question right now.

1 And so I would say I don't want to give an answer
2 to it should be -- there should be federal subsidies or
3 there shouldn't. We understand having federal and state
4 things combined adds complexity. I don't think we have to
5 work out every single detail to give a directional
6 recommendation, and I would say that we should not -- I
7 would not prefer to vote on the answer to that question
8 without more analysis about how it adds up from the
9 perspective of how much subsidy we can buy for kids in
10 either way. So I will leave it there.
11 CHAIR ROSENBAUM: Okay.
12 COMMISSIONER CRUZ: Joanne, thank you so much.
13 Thank you so much not only for the presentation and for
14 summarizing all the discussion, but for sort of logically
15 taking us from all the discussions that we have had for the
16 last year. I mean, it's a perfect example of how ideally
17 policy development should be from analysis of existing data
18 to what is happening to where we're going. And I think
19 this is the product of all those conversations that we have
20 had for the past few years, so my kudos to all the staff
21 and especially to Joanne.
22 I think in fairness this is a great summary that

1 also for a better sort of substantial understanding of this
2 requires a reading of the material that you have in,
3 because there's a lot more than is just on the slides.
4 In terms of the specific of it, I do agree with
5 Peter and Andy in the funding for five years. I think that
6 is reasonable, and I think there is precedent for it.
7 And we did not actually coordinate this, I should
8 say, but I have also my hesitation about the dropping of
9 the maintenance of effort, especially when we are sort of
10 introducing many changes that the states are going to have
11 their plate full in terms of what should we do. Are we
12 going to buy exchanges? Are we going to keep CHIP? Are we
13 going to submit a waiver for this? And the eligibility of
14 these kids may be at peril when they are considering all of
15 these options.
16 I think the federal evaluation is key, and I
17 think it's excellent that we are asking for the Secretary
18 to assess the intergovernmental coverage and access to
19 care, and especially in terms of coverage levels and
20 benefits.
21 I've said before I do not -- I have my -- not my
22 hesitation in terms of the using of the federal exchange

1 subsidies, but understanding better what that means and
2 what is it that we are trying to achieve. We understand --
3 and this is a question I have. If we suggest or recommend
4 for the states to be able to use the federal exchange
5 subsidies to cover CHIP, that requires a change in the IRS
6 Code, doesn't it, in the Tax Code?
7 MS. JEE: Yeah.
8 COMMISSIONER CRUZ: Because that's the --
9 MS. JEE: Yeah, it would certainly require some
10 sort of legal change to enable that to happen.
11 COMMISSIONER CRUZ: It's a little bit more
12 complicated. So I think that requires a little bit more
13 discussion before we move forward with that.
14 CHAIR ROSENBAUM: Just to be clear, everything we
15 recommend will require legal change. So you shouldn't be
16 worried that the Internal Revenue Code is somehow scarier
17 than the Social Security Act.
18 COMMISSIONER CRUZ: Okay.
19 [Laughter.]
20 COMMISSIONER CRUZ: Well, you have to be
21 cautious.
22 Also, I want to also emphasize -- and I'm glad

1 that it's here -- beyond the federal evaluation, as we have
2 talked before, the issue of assuring network adequacy is
3 really very important in terms of we don't want to go back
4 on how -- all the achievements of CHIP, and that has been
5 one of the achievements sort of assuring as much as they
6 can proper network adequacy.

7 I have another question, and this is my final
8 question. Are we also suggesting that within the
9 exchanges, both federal and state, there is the possibility
10 that the exchanges create a new program or a subset of a
11 program that exists to cover CHIP-eligible children?

12 CHAIR ROSENBAUM: So are you asking whether this
13 option would be an option regardless of whether a state
14 uses the state or federal exchange?

15 COMMISSIONER CRUZ: That's part of the question.
16 And the other question is: Can Blue Cross and Blue Shield
17 create a subprogram within their exchange program just to
18 cover these children that will be different in terms of
19 benefits and stuff than the regular program?

20 MS. JEE: So as far as staff thinking goes, you
21 know, it really would use the exchanges. So whether it is
22 state-based or whether it is the federal exchanges, there

1 are different issues for states that would take up the
2 option if they are -- if they have a federally run
3 exchange.
4 In terms of whether an issuer could create
5 another product -- I think that's maybe what you're saying
6 -- for the CHIP-eligible children, I think that that
7 certainly could be a possibility. Right now, the exchanges
8 -- the exchange rules govern, you know, the benefits on the
9 EHBs as well as the actuarial value of the plans. So if a
10 plan were to be -- if a plan wanted to offer something
11 different with a different sort of cost-sharing structure
12 than what they already -- I'm sorry. If an issuer wanted
13 to offer a product with a cost-sharing structure different
14 than what they already offer, they would still need to sort
15 of work within the actuarial value requirements of the
16 exchange.
17 CHAIR ROSENBAUM: The assumption here would be
18 any plan sold on the exchange, as Joanne notes, would have
19 to meet qualified health plan requirements.
20 MS. JEE: Exactly.
21 CHAIR ROSENBAUM: But what we are essentially
22 saying is that in consideration for giving states some more

1 flexibility to shape their markets, you know, lots and lots
2 of discussions over the past several years now about how to
3 create a more stable insurance market. So if a state
4 wanted to test potentially a different approach to its
5 insurance markets, it could do so on the understanding that
6 the plans it was buying for children in a more unified
7 market met CHIP requirements.
8 So what we've been able to discern over several
9 years of study -- and stop me if I'm wrong, Peter, or
10 anybody, Andy, anybody -- is that in a nutshell the benefit
11 classes that have to be covered in qualified health plans
12 are not different. And, in fact, there's an argument to be
13 made that they're actually a broader set of benefit classes
14 than one finds in the CHIP statute. I'm not worried about
15 what the states might do with that for the moment.
16 Where there's a dramatic difference is the
17 actuarial value. So I am assuming that if we made
18 recommendations about a new flexibility option but an
19 option that would require states to reflect certain CHIP
20 expectations, that the crucial issue is the actuarial value
21 of the benefit classes. There well could be other places
22 where if you lined up the standards for the sale of CHIP

1 plans federally and the standards for the sale of CHIP
2 plans, qualified health plans federally, there might be
3 other differences. But where there might be even more
4 differences is a state's own standards. You know, a state
5 may have extensive regulation of the sale of a CHIP plan
6 that doesn't apply to the sale of its exchange plans.
7 And so this would have to be undertaken on the
8 understanding that probably the Secretary of HHS be given
9 authority to work with states that wanted to do this --
10 VICE CHAIR GOLD: That's the innovation --
11 CHAIR ROSENBAUM: Yeah, exactly. To align their
12 existing CHIP policies with their exchange policies. But,
13 quite frankly, this is the irony. I'm putting on my
14 insurance lawyer hat. To the extent that there are sizable
15 differences, a lot of those differences are a matter of
16 state law and not federal law. So if a state wanted to go
17 this route, it would basically be saying what I'd like to
18 do is come up with a more unified set of pediatric policy
19 expectations that are at least as good as CHIP. You might
20 have a sense of lifting -- lifting the boats in the
21 exchange market.
22 COMMISSIONER CRUZ: Yes, that would be a benefit

1 [off microphone].

2 CHAIR ROSENBAUM: Yeah.

3 COMMISSIONER CARTE: Thank you. As others have
4 noted, I think that a lot of uncertainty has entered into
5 the exchanges since we had our May discussion, so I think
6 it would be appropriate to revisit the maintenance of
7 effort. It should at least be comparable to the duration
8 of the extension, and I think that the five-year extension
9 sounds reasonable. Hopefully we would know where -- that
10 we're in a better place by then.

11 Where we mention under the optional
12 considerations that public notice would have to be given, I
13 guess I would like to make a special plea to the
14 Commission. I've mentioned it maybe in passing before, but
15 more formally to say that public notice usually involves 30
16 days, and the CHIP directors as well as the Medicaid
17 officials who administer CHIP programs, after our
18 experience with implementing the stairstep transition, and
19 that really this takes about a year's time. There are the
20 budgetary considerations, the considerations of where
21 children are in the course of treatment, and many other
22 things, that this would be a one-year advance declaration

1 that the state intends to make, you know, this transition.
2 And that would be most helpful, as well as, you know, CHIP
3 -- the states and the CHIP programs now have twice had to
4 go through this kind of hyper-uncertainty, both through the
5 reauthorization back in 2009 and again, you know, last
6 year. And while everybody seems to take it for granted
7 that in all likelihood it will continue, it's very
8 difficult for state officials to be in that place.
9 And then, lastly, I would just mention that I'm
10 glad that we are all together on the consideration of the
11 expiring provisions for CHIP that cover express lane
12 eligibility and outreach and the pediatric quality measures
13 and the obesity demonstration projects. I would hope,
14 though, that we could say -- give more emphasis -- I think
15 the pediatric quality measures, when that was written into
16 CHIPRA, was probably in deference or emphasizing that the
17 children's pediatric core measures at that time had come up
18 and that we might more broadly emphasize that those funds
19 could be used for value-based projects that -- and medical
20 home, whatever, but a little bit beyond just pediatric
21 quality. And that's important to me because pediatric
22 quality I think still is -- it gets short shrift. You

1 know, the focus, as, Andy, your paper in New York by Bailit
2 shows that we're really not giving sufficient attention to
3 what pediatric quality means currently.
4 COMMISSIONER THOMPSON: Well, first of all, thank
5 you, and I agree with much of what has been said
6 particularly about the formulation of the straw man, and
7 particularly around extending CHIP. I could have gone for
8 more than five years, too, partly because I think if we are
9 really serious about thinking that we want to support state
10 innovation activities, that really a five-year program does
11 not give a lot of time for people to work on designing and
12 implementing and operating and evaluating a program like
13 that. But I also recognize that a five-year period is a
14 pretty typical window here, so I can buy that.
15 I guess I will be in the minority in speaking of
16 the straw man's approach to retaining current law with
17 respect to MOE. And my argument for that is really tied up
18 in kind of the package of provisions that we have tried to
19 arrange here, where we phase down over a period of years
20 the 23 percent point differential and provide a further
21 incentive at the end of that period for states to maintain
22 or expand CHIP eligibility.

1 You know, it's my fervent hope that states would
2 not reduce CHIP eligibility, so I think the question,
3 though, is: Whose decision should that be? And I think
4 that the combination of phasing down and getting states
5 used to over a period of several years a lower match rate
6 and providing that additional incentive will position
7 states to make a reasonable choice for them going forward.
8 And for all of the reasons that we have discussed that CHIP
9 is so important, because it has such support, there's a lot
10 of evidence about it works and it produces outcomes, I
11 would hope that it could stand on its own in a state at the
12 end of the expiration of MOE and make the argument for
13 itself, and a state would then evaluate that evidence and
14 information and decide to continue the program and to
15 continue to strengthen the program. But I would be
16 uncomfortable with a federal requirement around MOE which,
17 appreciating all of the things that we've said about why we
18 want to see CHIP maintain current eligibility levels or
19 even expand and why we're concerned about continued
20 instability around the insurance market, at some point I
21 think -- and this has been a long MOE period -- I think
22 that MOEs should be relieved from the states for them to

1 take in all of the requisite information and make some of
2 those decisions for themselves based on their markets and
3 based on their populations.
4 COMMISSIONER BURWELL: I was just going to follow
5 up [off microphone] --
6 CHAIR ROSENBAUM: Mic.
7 COMMISSIONER BURWELL: -- the MOE provision and
8 the declining matching rate. In the declining matching
9 rate, does that mean that the amount of federal funding we
10 estimate will decline every year for five years?
11 CHAIR ROSENBAUM: It was raised very high, and so
12 what we're recommending is that -- not recommending. What
13 we are considering at this point is recommending that it
14 come back down to the normal enhanced CHIP rate.
15 COMMISSIONER BURWELL: My question was: What is
16 the impact on the CBO estimates of that reduction?
17 MS. JEE: So the CBO estimates account for that,
18 the phase-out of the 23 percentage point --
19 COMMISSIONER THOMPSON: And it's my assumption
20 that most of the costs in the CBO estimates are about --
21 they would have scored in the baseline no more enhanced
22 rate at all, right? Is most of the cost in the CBO

1 estimate associated with the fact that we are phasing out
2 rather than outright eliminating the 23 percent match,
3 increased match?
4 MS. JEE: I mean, to phase out the 23 percentage
5 point bump would save money.
6 COMMISSIONER THOMPSON: Because they have in the
7 baseline that in perpetuity?
8 MS. JEE: No.
9 COMMISSIONER THOMPSON: That's what I'm saying.
10 EXECUTIVE DIRECTOR SCHWARTZ: Okay. If you kept
11 it passed the point at which it expires now, it costs
12 money. If you get rid of it immediately, it saves money.
13 And if you ratchet it down, it's somewhere in between.
14 What we can't tell you is of this estimate, how much of it
15 is attributable to what we're proposing. I think we saw an
16 earlier estimate. That if you just allowed it to expire --
17 and I can't remember what it was in combination with -- the
18 whole thing became a saver. But it was a much more narrow
19 question we were asking at that point. So there is cost
20 associated with the phase-down and keeping it at that five
21 percentage point differential.
22 COMMISSIONER COHEN: Can you just remind us long

1 it's been? It's been in place for one year, the 23 percent
2 bump? Is it currently in place?
3 MS. JEE: Yes. 2016.
4 COMMISSIONER BURWELL: I guess I will join the
5 minority of Penny in terms of allowing the MOE to expire.
6 I do think -- I mean, and I agree it's a matter of a state
7 decision, and I would hope that they would continue, you
8 know, without that federal requirement.
9 I guess I'm also somewhat skeptical -- this is
10 nickels and dimes -- about extending the funding of
11 pediatric quality measures, $10 million a year for another
12 five years. I think we ought to be able to develop
13 measures with $20 million.
14 In regard to developing value-based purchasing
15 with those quality measures, I think that is something that
16 is happening in the mainstream in development of new
17 payment models already. I don't think additional funding
18 is needed for that.
19 COMMISSIONER COHEN: With all due respect, not so
20 much for kids. In all population, yes. Not for kids.
21 CHAIR ROSENBAUM: So the other point is --
22 Joanne, I don't know if you can shed light on this, and

1 maybe Penny, from your past, if you can -- and that is the
2 money is not just for the process of developing the
3 measure. I assume that the money -- oh, Sharon, of course,
4 you can too -- the money is for the act of actually
5 applying the measures, collecting the data, evaluating the
6 results, making refinements. I assume it's a sort of an
7 ongoing performance measurement improvement system, really,
8 not just experimental measurement.
9 COMMISSIONER BURWELL: I'm willing to be talked
10 out of that.
11 [Laughter.]
12 CHAIR ROSENBAUM: I wanted to make sure that --
13 COMMISSIONER SZILAGYI: That's correct. The AHRQ
14 spent the money to develop the measures and this is really
15 for the implementation and trying to cycle back to improve
16 quality.
17 VICE CHAIR GOLD: Peter, if they didn't have the
18 funding, would there be a risk that we wouldn't have
19 uniform measures across the state?
20 COMMISSIONER SZILAGYI: Sharon would know, but I
21 thought some of this money was used for the IT systems and
22 for sort of just administrative and all the infrastructure

1 type of work to use the measures. That's what I thought but
2 I may be incorrect.
3 EXECUTIVE DIRECTOR SCHWARTZ: I think it's fair
4 to say that that they're not uniform now. I mean, the
5 states' reporting of the pediatric quality measures still
6 leaves a lot to be desired.
7 COMMISSIONER BURWELL: And are these quality
8 measures specific to the CHIP population, or are they
9 specific to Medicaid children?
10 COMMISSIONER CARTE: To Medicaid.
11 COMMISSIONER SZILAGYI: Low-income children.
12 COMMISSIONER CARTE: And they're HEDIS measures,
13 by and large.
14 CHAIR ROSENBAUM: And the reporting -- I was
15 looking at one of the reports. I don't look at these
16 things very often but I was looking at one of the reports
17 and it was quite -- I mean, a lot of states were reporting
18 a lot of measures at this point. So it's gotten much
19 better, I would say, over the past three or four years.
20 I have Brian and then Stacey here, and then --
21 [Speaking off microphone].
22 COMMISSIONER GORTON: Yeah, really. So with

1 respect to duration I will own that I was leaning towards
2 the shorter end of the spectrum, and largely because of the
3 argument -- I didn't want to just sort of be kicking the
4 can down the road and letting things drift, and I was not
5 initially thinking that we needed a whole five years in
6 order to move the ball.
7 But I am moved by the arguments that have been
8 made about how slowly this particular ship will turn, and
9 so I'm okay with five. If we've gotten much more than five
10 then I would be far more resistant than I am now.
11 With respect to maintenance of effort, I'm where
12 the folks on this side of the table are.
13 [Laughter.]
14 COMMISSIONER GORTON: Or at least some of us.
15 You know, I don't see any reason to extend that and I would
16 just add another piece of it. We tend to focus maintenance
17 of effort conversations around what we think are
18 deficiencies of states at the low end. If we actually
19 expect states who have high levels of eligibility to be
20 able to put this in place in some sort of new merged
21 marketplace, you may have to move people out of Medicaid,
22 out of CHIP, into a qualified plan, and the current

1 language around maintenance of effort, as I understand it,
2 and I'm not as deeply steeped as you all are, I think that
3 would form a barrier.
4 And so I'm inclined, overall, to let it stop, but
5 if it doesn't get stopped there needs to be some way that
6 the states can get credit. As long as they're providing
7 coverage to those bands of eligibility, to a qualified
8 children's health plan, then that should -- they ought to
9 get some credit for that, although, again, I would overall
10 let it stop.
11 I'm feeling a little more draconian, particularly
12 because it could help us turn this into a saver around the
13 23-point bump. I'm not the expert here but you all have
14 said it didn't work. And I don't know why you would
15 persist in phasing out a huge chunk of money that when in
16 with the idea that it would do something that it doesn't
17 do. And I understand people are spending it for other
18 stuff. You know, it folds. But, you know, was that really
19 the purpose?
20 And so I guess me, personally, I would be
21 inclined to dial that down pretty quickly -- maybe not
22 immediately because that's a rate shock to states, but, you

1 know, they're doing their budgets year by year and I don't
2 know that necessarily it needs to be until 2020 to figure
3 out how to live with a lower rate. I don't have a problem
4 with continuing 5 percentage point piece.
5 With respect to the subsidies, I guess I don't
6 think we need to decide that here. I think we should
7 include it in the recommendation as an option for the
8 states, which the secretary will figure out how to
9 effectuate, and the states will figure out what they want
10 to do, and there will be, you know, an innovation waiver or
11 a state plan amendment, or some other authority that gets
12 negotiated, and the states will do that. And you're going
13 to have to figure out -- because in this sort of new merged
14 marketplace you're also going to have to factor societal
15 into it.
16 So I think it could be somewhat complicated but I
17 don't think we have to solve for that here. The point is
18 that what we are creating is flexibility for the states to
19 try and deal with children the way they have dealt with the
20 rest of their health care marketplaces, in a way which is
21 responsible, but which gives them some flexibility.
22 So I would be inclined -- I know Andy said she

1 didn't want to vote on this -- I would be inclined to say
2 we ought to include both of these options now, from the
3 get-go, and then leave it to the regulators and the state
4 officials to figure out to implement it.
5 With respect to the additional -- I'm having
6 trouble reading this whole thing. Oh, that's the wrong
7 page. That's why.
8 Innovation waivers, I think, is a great idea.
9 Again, you know, I think it may involve more than just
10 Medicaid, and so we need to make sure the secretary has the
11 flexibility to deal with that.
12 Expiring provisions, I'm assured by my friends on
13 the Commission who are experts in CHIP that these are all
14 good things and useful expenditures of federal funds, and
15 so I'm happy to have them continue.
16 COMMISSIONER LAMPKIN: To weigh in on some of the
17 parameters and the straw man, with respect to the extension
18 others have made a very eloquent argument for that. I'm
19 completely on board there.
20 With respect to the duration of the extension, I
21 find Penny's comments about demonstrations and how long
22 they take to be persuasive, and so if we think we are in a

1 position where we may be recommending those middle two
2 pieces, I think -- the exchange and the innovation waiver
3 those may be arguments for being higher than five. I
4 agree, I think, with Peter, who said five should be the
5 minimum, that that makes sense. But I could see seven or
6 eight, also, especially if we wanted to push the
7 demonstration side of this, for the reasons that Penny
8 noted.
9 With respect to the exchange -- oh, the MOE. I'm
10 here with let's give the states who have a budget
11 responsibility the opportunity to design their program,
12 especially if we're not maintaining the 23 percent, then
13 they should -- the MOE should expire. If we feel that the
14 uncertainty around the exchange is so worrisome that we
15 need to maintain the MOE, then maybe we have some
16 obligation around maintaining the enhanced FMAP, but that
17 is a more expensive option. But that seems, from a state
18 budget perspective, to be the fair thing.
19 I am curious about the 5 percent long term. If
20 we let the MOE expire, we ramp down the enhanced FMAP, and
21 we go with the 5 percent, this is something that I don't
22 think many people have commented on. Is 5 percent at 250

1 the sweet spot and we're already there, we don't need to
2 discuss that further? Is there a two-tier approach that
3 makes sense -- 5 percent at 250, 10 percent at -- or some
4 mix of 10 percent at 250, 5 percent at 300, or some other
5 combination that is worth discussing, or are we just -- we
6 landed in the right spot right away.
7 CHAIR ROSENBAUM: [Off microphone] -- the 5
8 percentage point number is an incentive, and if so, what is
9 the frame of reference.
10 COMMISSIONER LAMPKIN: Yeah. Exactly. Is that
11 really where -- is that the right place? I don't know the
12 answer. I just -- I'm surprised we haven't discussed that
13 aspect more.
14 And then on the exchange question, this is
15 appealing to me if we are talking about giving the states
16 an opportunity to stand up like a super-platinum, cost-
17 sharing, child-only plan on the exchange, or bring that
18 CHIP population to help that thing be -- health insurers
19 want to provide that product, because here's the CHIP
20 population to help form the risk pool for it, and provide
21 that opportunity through children who are not CHIP-eligible
22 to buy and get a federal subsidy if they're eligible for

1 one, above the CHIP level. That's very appealing, if that's
2 where we're going there, and that's why, to me, to have
3 that stable risk pool and the opportunity for the higher-
4 income kids.
5 And the innovation waiver for similar ways, to
6 give states the place for those to merge.
7 So all that, in general, sounds good to me.
8 CHAIR ROSENBAUM: I don't want to put Leanna on
9 the spot but I'd really love to hear from you. So we have
10 people who live these programs as administrators, or who
11 have lived these programs as administrators, but you've
12 lived the program as a family that benefits from them.
13 So what I'd like to know from you is, you know,
14 if you were a queen, or just an influential MACPAC
15 commissioner, on this maintenance of effort issue -- so we
16 either, you know, it's 2019 and states are free, maybe, to
17 make their own decisions, because the MOE doesn't continue
18 after that date and they can drop down their Medicaid
19 eligibility, drop down their CHIP eligibility. We have had
20 one state, you know, make very significant changes, came
21 back into the CHIP program. And then, you know, on the
22 other side of the coin is the issue of not wanting to --

1 you know, not wanting to open that door.

2 So I'm curious where you are on this.

3 COMMISSIONER GEORGE: Well, I'm probably more or
4 less on the fence but leaning towards letting it expire in
5 2019. It sounds like it's been an effective MOE for the
6 last almost 10 years at that point, which is a long time
7 for states not to have the ability to really tweak the
8 programs and stuff, in accordance to what the market, the
9 economy, and stuff like that is at that time.

10 But, of course, I think, you know, as Penny
11 alluded to earlier, extending the MOE but dropping the --
12 what was it called? -- the enhanced match rate at the same
13 time would not be a good thing either because, I mean, like
14 I imagine a 25 percent drop in my income, or having a 25
15 percent increase in my expenditures would be -- for most of
16 our states are all on balanced budget amendments and stuff
17 like that, it would be hard.

18 CHAIR ROSENBAUM: Yeah. You know, what I was
19 thinking as we've been having this discussion was the MOE
20 essentially takes a snapshot of what your programs look
21 like, in 2010, and said this is your program. And I'm
22 wondering whether one possible thing to think through is an

1 MOE that picks up on the upper limit, okay. And, you know,
2 if your highest eligibility limit for your pediatric
3 programs was 250 percent of poverty, you can't go below
4 that. But within that, if you were doing Medicaid up to
5 200 and CHIP up to 250, if you wanted to do Medicaid to 150
6 and CHIP for the remainder, or bring Medicaid up higher and
7 have more Medicaid than you did before.

8 In other words, the MOE has several moving parts
9 to it, because it's an MOE that's applied to two programs,
10 right? So the question is whether what we're really
11 interested in is the highest income eligibility or the two
12 programs precisely as they existed. I don't know.

13 Peter.

14 COMMISSIONER SZILAGYI: I appreciate everybody's
15 points. I think everybody is making a really good point.

16 Let me make another pitch for the MOE. So I've
17 never seen a study that shows that a child in Alabama who
18 is 150 percent of the poverty level is that different than
19 a child in Minnesota who is 150 percent of the poverty
20 level. The studies I've seen have suggested that kids,
21 whichever state, who are 150 percent, are higher risk than
22 kids who are 400 percent, in the same state.

1 So I've been concerned for a long time about
2 this. You know, on the one hand I really want states to
3 have flexibility and innovation, and on the other hand I
4 think it's just concerning to me that state policy or
5 political decisions might affect the health and ultimate
6 outcomes of a child, if you ever happen to be born in one
7 state versus another, as opposed to an adult. So that was
8 one point.
9 The second point is, to me, the MOE is protection
10 because I wouldn't limit how high states could go. I would
11 limit how low in eligibility states could go, and whether
12 you can blend Medicaid -- or, you know, kind of combine
13 Medicaid and CHIP. That's okay to me, but to me this is
14 sort of a sense of protection which is a large part of what
15 insurance is all about, and it sort of depends -- you know,
16 there's no right or wrong but it depends on where we want
17 to draw the line.
18 The third point is I find a contradiction between
19 stopping the MOE or letting it expire and the 5 percent
20 concept. If we really believe that adding only 5 percent
21 might induce states to raise the eligibility all the way up
22 to 250 percent -- because, you know, they get only 5

1 percent more dollars -- then I think states will drop the
2 eligibility criteria once the MOE expires. I mean, I think
3 it's a contradictory, in my mind, to say that only 5
4 percent extra money is going to sort of convince states to
5 go much higher, but, you know, why doesn't the incentive
6 work, you know, in the other direction?
7 VICE CHAIR GOLD: Yeah, and I'm going to ask
8 Joanne for help, if she remembers, and maybe if she doesn't
9 she can look over some things.
10 I thought that we did some talking about the 250
11 percent at one point. I mean, it didn't -- the 5 percent
12 may have come out of thin air. I thought the 250 percent
13 didn't and it was based on some thought you had, that you
14 had said, Peter --
15 COMMISSIONER SZILAGYI: No, no. I'm saying it
16 was just a --
17 VICE CHAIR GOLD: -- that was important. But
18 also that I think our concern was that there still are some
19 states. I remember looking at states and some of them were
20 still below that, and can we get them up. I think it was
21 less that we thought people might come down to it as we
22 were concerned that despite everything that's been done we

1 still don't have a uniform floor of 250 percent for all
2 kids, and is there any sweetener? That's at least the
3 discussion I'm remembering, which, you know -- so maybe
4 people can fill in and then we can at least answer Stacey's
5 question, and then talk about whether the link between MOE
6 and that is that critical.
7 COMMISSIONER SZILAGYI: I was just trying to make
8 a point that if a very small incentive will potentially
9 change state policies to increase the eligibility, then a
10 small incentive within a state to try to save a small
11 amount of money might induce them to go down as well. And
12 so bridging that together with my argument about
13 protection, that's why I'm suggesting to maintain the MOE.
14 CHAIR ROSENBAUM: I also think it's worth
15 remembering that when the original MOE expiration date was
16 set, the assumption was that we be on this 10-year glide
17 path into a world in which the individual market would have
18 25 million people in it, everything would be functioning,
19 you know, smoothly, and things would have settled into a
20 universal coverage scheme whereby then, if the state wanted
21 to think about somewhat lower Medicaid eligibility levels,
22 or, in fact, you know, CHIP, in theory, might have gone

1 away entirely.

2 So the 10-year rule has so much noise underneath
3 it, in terms of the picture that was painted in people's
4 heads as they were thinking, 10 years is plenty of time to
5 sort of get ourselves positioned in this new insurance
6 world. And, of course, what's happened is that it's been a
7 bumpier ride than that, and I think, myself -- and I
8 struggle with this question because I'm actually, on these
9 kinds of issues, particularly in states that are states
10 that have sort of, really have taken the bull by the horns
11 and are running a new insurance system, okay -- in those
12 states the time may have arrived to give them the
13 flexibility that we all anticipated, you know, almost 10
14 years ago, they should have, and unfortunately, at this
15 point, the MOE, it sort of factors over our heads in terms
16 of not just the states where things are sort of -- the
17 throttles are kind of working the way we expected, but
18 we've got some states out there where it's not. And so we
19 have this bifurcated world and, you know, a lot of
20 uncertainty.

21 And so the theory behind the MOE's expiration
22 after 10 years shifts a little bit, and I think it's worth

1 just noting that.

2 Penny and then Andy.

3 COMMISSIONER THOMPSON: So I'll make my other

4 pitch, too, going back. I think you can think of the MOE,

5 Sara, in the way that you described the original hope,

6 which was that you'd have this a period of time, things

7 will settle in, you'd have this robust market, et cetera,

8 et cetera.

9 Another way that you can think of it is you had

10 your chance, right? And, you know, enough is enough. You

11 have a period of time that you've invested and settling

12 into whatever the world is going to look like, and maybe

13 it's perpetual instability, or maybe it settles out

14 someplace different than you thought it was going to settle

15 out. But you would still at that point cede decisionmaking

16 to the state.

17 And one of the things that we've said is the

18 strength of the CHIP program, among the many strengths of

19 the CHIP program, is the state endorsement of it, their

20 excitement to have CHIP programs and to run them and to see

21 them succeed. And so I'm just very concerned about an

22 approach that continues to mandate that they stay locked

1 into that one period in time where they were sitting there
2 at that given moment that a federal law passed and said
3 that's where you have to stick regardless. And I do think
4 that at some point the program has to make its own argument
5 that it does produce results, it is something that people
6 value, it is something that contributes to the overall
7 state of health for the nation and for individual states.
8 I want to also then just pick up on maybe
9 something Kit said, which is maybe this is -- I don't know
10 how many variations we want to go through of different
11 models. I understand. But Kit made the point maybe we're
12 being a little too generous about this phase-out of the 23
13 percent. Maybe it could be a faster or steeper glide path
14 down to existing match. And, you know, maybe there is some
15 potential trade-off there to steepen that decline while
16 still giving states ample time to plan and adjust to the
17 difference, and maybe build up the incentive after
18 expiration of the MOE and put dollars after the MOE has
19 expired if states achieve or maintain an eligibility level
20 of 250 percent. And so maybe that would be one way in
21 which to bookend the two sides.
22 So, on the one hand, you know, we don't want to

1 take you from 100 to zero, you know, in two seconds, so
2 we're going to provide some phase-down.
3 On the other hand, MOE is going to go away, but
4 when MOE goes away, we're also going to create more
5 encouragement for you to maintain or achieve an eligibility
6 level of 250 percent by adding a bit more match on that end
7 of the equation.
8 COMMISSIONER COHEN: All great points. I'm going
9 to add just a couple more, and you gave me an idea, too.
10 We've done all of our modeling on what CHIP looks
11 like as of basically 2009 and recently, and we said CHIP
12 for the most part, from actuarial value, from other things,
13 that it looks better than what's available in the exchange.
14 But the one thing we really rarely talked about is that
15 CHIP can change a lot, and that's one of its upsides and
16 one of its downsides. But we have been in a period where
17 CHIP has looked good because it's been locked in. And I
18 just want to remind us that, you know, when you say no MOE,
19 it means that wait lists can start in 2019, and we have
20 been talking a lot about trying to maintain and promote
21 children's coverage. Just like the ACA moved things
22 forward, we want to move things forward in that regard.

1 So I want to be clear that all of our modeling
2 has been based on what CHIP looks like today and it could
3 look a heck of a lot worse under federal law, existing
4 federal law, if the MOE goes away. It could look very,
5 very different in a bad economy and otherwise. So we just
6 have to really be -- like acknowledge that and be
7 comfortable with it.
8 You gave me an idea, though. I think the issue
9 around the 250 percent is that there's many states that are
10 nowhere near 250 percent. So if 5 percent is not going to
11 encourage them to go from 170 to 250, it's just not going
12 to happen.
13 What if, though, we did connect some lesser
14 reduction than 23 percent to an MOE where you are? Because
15 I think the take-up of the 5 percent is going to be
16 relatively low in states that already have relatively high
17 coverage -- not the states that are low and that are
18 probably at most risk of dipping below if there's a change
19 in the MOE.
20 So my suggestion, could we design something where
21 we say you have a phase-down in your FMAP, but it never
22 goes beyond, say, 20 percent, 18 -- whatever the number is,

1 and we'd have to do some math -- if you keep your levels
2 steady, if you maintain the MOE?
3 And the other thing I would say is Kit's point is
4 incredibly important. An MOE is meant to be like a floor
5 but not a calcification, and we have to just make sure that
6 any -- you know, that's really for real drafters and
7 legislation, but that we write it in such a way that we are
8 not limiting the ability of change, just not real
9 reductions in eligibility.
10 CHAIR ROSENBAUM: So just to try and make sure
11 we've got sort of the variants here, one option is keep the
12 MOE, phase down the money, as we're talking about here.
13 Another is phase down the money but get rid of the MOE, and
14 then there's maybe this middle ground of eliminate the MOE
15 but use an incentive instead where the enhanced federal
16 funding would fall only to a certain point for states that,
17 in fact, stayed at least where they were.
18 Now, what if a state wanted to climb? If a state
19 wanted to climb, would it get the enhanced match or it
20 would only be --
21 COMMISSIONER COHEN: I mean, we're trying to [off
22 microphone] 5 percent bump presumably. We are trying to

1 incentivize higher coverage levels.

2 COMMISSIONER THOMPSON: You know, just one point
3 to make on this conversation, which is MOE does maintain
4 inequities among states, versus what we had written in the
5 straw man was about trying to encourage everyone to get to
6 that 250.

7 CHAIR ROSENBAUM: Right, come up.

8 COMMISSIONER THOMPSON: There might be, you know,
9 a worthwhile conversation about which one of those goals
10 are we really trying to maintain. If we had limited --
11 which we do have limited money. There isn't unlimited
12 money. If we have limited money and we're trying to invest
13 it, is it more important to encourage states across the
14 country to be at that 250 level or for whatever they looked
15 like in 2010 --

16 COMMISSIONER COHEN: I would say that creates
17 more disparity, because you get the states that are at, you
18 know, 230 or 225 right now, and 250 really doesn't seem
19 like a very big climb, and they get a nice bump. And
20 states that are struggling with low -- you know, have low
21 levels and extreme budget pressures go down. I would say
22 were spending -- you know, we're not spending our money to

1 that level. We're spending our money on states that have
2 already committed more money in the first place. So, I
3 mean, it's a fair discussion for sure. I don't think
4 there's an obvious answer, but I think that almost promotes
5 sort of some more disparity, because, again, the states
6 that can't -- that don't see 250 in their realistic sights,
7 they're off the table for that conversation.
8 COMMISSIONER THOMPSON: Yeah, I'm just pointing
9 out that in the straw man, the 250 is the standard that
10 we're trying to achieve versus let's maintain whatever you
11 had in 2010. And I think we should be clear amongst
12 ourselves --
13 CHAIR ROSENBAUM: What are we really aiming for?
14 COMMISSIONER THOMPSON: If we're trying to put
15 some money behind something, what is it we're trying to do?
16 COMMISSIONER SZILAGYI: Do you mean if they're
17 mutually exclusive? I don't understand -- I didn't follow
18 your point at all about why --
19 CHAIR ROSENBAUM: Can we get Kit [off
20 microphone]?
21 COMMISSIONER SZILAGYI: Oh, I'm sorry.
22 COMMISSIONER GORTON: So I guess where I'm stuck

1 is -- and I don't follow this literature, so you guys
2 educate me. Do we have any evidence that throwing any
3 amount of money at these states is going to get them to
4 push their eligibility levels up? Because, I mean, 23
5 percent didn't seem to do much, and that would seem to me
6 like, you know, a material --
7 COMMISSIONER COHEN: It does change the
8 calculation for going down -- I do know that -- because you
9 save less. I mean, you save less by going down.
10 COMMISSIONER GORTON: Fair enough. But I think
11 we shouldn't fool ourselves that we can design an incentive
12 program, particularly one with a huge price tag that's
13 going to be very unpopular with a lot of people. You know,
14 they're looking for us, if we can, to save money. I don't
15 think necessarily we can do that. But we shouldn't either
16 leave money in the budget or put more in to try and
17 accomplish something if, as an evidence-based organization,
18 we have no evidence to suggest that's going to work.
19 CHAIR ROSENBAUM: We are living through the test
20 of the century of this. As a resident of a state that
21 seems not to be moved by 100 percent funding for poor
22 people --

1 COMMISSIONER GORTON: Well, I mean, exactly.
2 CHAIR ROSENBAUM: So money is, I think -- I mean,
3 I think we're all sort of sensing that the money issue may
4 be less the issue than others. I mean, I think we now have
5 the greatest empirical research we will ever have about the
6 fact that money does -- you know, money is only of limited
7 value in --
8 COMMISSIONER GORTON: Right. It's a wonderful,
9 natural experiment in terms of how states are going to
10 decide how they operate in a federal construct. And --
11 CHAIR ROSENBAUM: Which is why the MOE then
12 becomes actually the more -- potentially the more important
13 issue.
14 VICE CHAIR GOLD: But the states didn't like --
15 the ones who didn't go for it didn't like the ACA. A lot
16 of states like CHIP. So --
17 CHAIR ROSENBAUM: It's not money.
18 COMMISSIONER GORTON: Right.
19 CHAIR ROSENBAUM: And my lovely home state is
20 also a state that, faced with a tremendous bump in CHIP
21 funding, has not done anything there either. So, you know,
22 it's -- I think it does sort of bring matters into

1 somewhat, you know, clearer [off microphone] about what --
2 how the calculus plays out.
3 COMMISSIONER GORTON: So to your point, if what
4 we said is, okay, money doesn't incentivize states to --
5 states are where they are because they're where they are,
6 it's where they're going to be. They may decide to go up.
7 We'd like them not to go down. Then maybe there's an
8 argument for some reengineered MOE that gives -- that
9 doesn't calcify us in 2009 but sort of maintains some level
10 of coverage. And then I would argue then what we should do
11 in terms of, you know, helping the nation spend money more
12 efficiently and cost-effectively, is get rid of the 23
13 percent very quickly.
14 CHAIR ROSENBAUM: Well, that's why before I
15 raised the issue of the top level. The MOE essentially has
16 two parts to it. There's the top level, you know, what's
17 the highest income level for public insurance coverage for
18 children in your state? But then because the MOE
19 essentially sits on top of two separate programs, there's
20 the sub-level of how you distribute children between the
21 two programs. So one issue is: Do we keep a top level
22 standard? If you were at 200 percent of poverty, you can't

1 go below 200 percent of poverty. But within that, if a
2 state were to want to shift more toward CHIP and away from
3 Medicaid, that would not be subject to the MOE.
4 COMMISSIONER GORTON: Well, so the only thing I
5 would say is we should include the third bucket, so CHIP,
6 Medicaid, and the tax credits and subsidies associated with
7 the exchange product.
8 CHAIR ROSENBAUM: Well, there you've got a
9 problem, though, because that -- because of MEC, because
10 there's no -- it's not a three stacker. You've got MEC
11 over -- you've got premium subsidies over here and you've
12 got Medicaid and CHIP acting as minimum essential Congress
13 over there. In other words, from a state's perspective, if
14 you wanted to be draconian about it, which one state
15 already has tried to do, you would just eliminate anything
16 above 133 percent of poverty and say children go into the
17 exchange. So the whole issue with the MOE is to not have
18 that kind of option --
19 COMMISSIONER GORTON: Right, but to have all the
20 children go into the exchange as it is currently
21 constructed, which Peter appropriately -- I wouldn't have
22 characterized it quite the way he did, because the

1 actuarial values in the exchange are --

2 CHAIR ROSENBAUM: You mean if your exchange

3 market looked different.

4 COMMISSIONER GORTON: So we create a children's

5 product, and we say, okay, if you have --

6 VICE CHAIR GOLD: We don't have that authority

7 [off microphone].

8 CHAIR ROSENBAUM: No, no.

9 COMMISSIONER GORTON: Congress does.

10 CHAIR ROSENBAUM: Were Congress to follow our

11 recommendation on the innovation, and the exchange products

12 were essentially upgraded, then what you're saying is do we

13 really need the MOE.

14 COMMISSIONER GORTON: Well, I'm saying that

15 states that enroll those people get credit for those

16 because they're in a qualified minimum benefit plan.

17 CHAIR ROSENBAUM: Yeah, yeah. I'm sorry. Toby

18 had his hand up.

19 COMMISSIONER DOUGLAS: I've been staying quiet,

20 but overall, you know, what I like about the straw proposal

21 is -- there's a lot about flexibility besides continuation,

22 which I strongly agree with -- is flexibility. When we

1 start then taking away and saying no, we're going to keep
2 the MOE, we're going against what CHIP started with, a lot
3 of state-driven autonomy and approach. You know, I just
4 think we're sending the wrong message. We want innovation.
5 You want to think about doing exchange -- you know, other
6 ways, but you can't know what's right in your state
7 approach, and we're going to still create this federal
8 overlay on that. And so I strongly don't agree with that.
9 CHAIR ROSENBAUM: That is certainly where I saw
10 the tension, and I completely reverberate to what Kit is
11 saying, although there's so many dependent, you know,
12 moving pieces, who knows where it would end up. But if
13 we're saying to states we'd really like to encourage you to
14 try something different with your insurance markets, and at
15 the same time that we're saying that, we're saying to them
16 but you really can't do anything different with your CHIP
17 and Medicaid markets -- although I suppose you could say
18 that it's still CHIP if they're rolled into the exchange,
19 you know, that's an interesting question. At some point I
20 find that we're a little confused, that's all.
21 But at the same time, I mean, I feel very
22 strongly that the MOE assumed a glide path that we've never

1 achieved, and so, you know, there's real cause for concern.
2 Well, we've certainly given ourselves a lot to
3 chew over here in terms of the next steps, which is just to
4 remind everybody, the staff are going to bring us an
5 attempt at a refined outline in October which will really
6 be, I think, the time for any last discussion because that
7 package then will come back to us for a recorded vote in
8 December.
9 VICE CHAIR GOLD: Just I hope we can go back to
10 what we said at the beginning. For many sessions we've
11 seen a lot of data. We've seen that -- you know, the whole
12 idea originally was CHIP would be able to be folded into
13 the exchanges. We looked at data and saw that we can't do
14 that. We looked at the political environment and saw that
15 that part wasn't getting any traction to have it done.
16 So I think our logic of going for, you know,
17 reasonably lengthy extension of CHIP while providing some
18 flexibility for those states that are able to come up with
19 some creative solutions that maintain the CHIP
20 requirements, pending figuring out this national role or
21 something, makes sense.
22 So I just don't want us to get too off track or

1 too complicated with this thing. I mean, I kind of like
2 the straw man thing, and I understand the debate on
3 maintenance of effort. I still have to think that over one
4 way or another. But I thought the straw man worked, and I
5 thought that I was hearing most people think that, in
6 general, it did. I'm just concerned that, you know, in the
7 interests of trying to deal with all sorts of good
8 intentions we have, that we not make things too
9 complicated.
10 CHAIR ROSENBAUM: Well, you know, who ever said
11 child health policy was easy? I mean, we deserve to be
12 every bit as complicated as everybody else when we're
13 dealing with children.
14 So we do have time for public comment, and I
15 invite those who would like to comment to come up.
16 Thank you. Thank you so much, Joanne. That was
17 great.
18 **### PUBLIC COMMENT**
19 * MR. REUSCH: I am Colin Reusch with the
20 Children's Dental Health Project. I appreciate all the
21 work that staff put into this and all the discussion, but
22 straw men are set up to be knocked down. I'm happy to take

1 a couple of blows.

2 It does, especially with regard to the subsidy
3 option, seem a little overly complicated and potentially
4 fraught, especially for oral health services for children,
5 given the current state of dental offerings in the
6 marketplace and how rules in the marketplace do and do not
7 apply to them, specifically with regard to cost-sharing
8 subsidies, which do not apply to certain dental offerings
9 to children.

10 In general, with regard to the five-year
11 timeline, I would encourage the Commission to think
12 realistically about how quickly the marketplaces are
13 proceeding towards an ideal situation with children and
14 remind them that they are not exactly proceeding with
15 alacrity.

16 And with regard to the MOE or some other form of
17 floor to maintain eligibility levels, I would ask the
18 Commission to consider the fact that states often do, when
19 given the flexibility, make decisions that perhaps are in
20 opposition to programs that do stand alone to make an
21 argument for themselves, so thank you.

22 CHAIR ROSENBAUM: Thank you.

1 MS. LOVEJOY: Hi. I'm Shannon Lovejoy with the
2 Children's Hospital Association. Thank you for the
3 opportunity to provide comments. We've been encouraged by
4 the discussion of providing a longer-term extension of CHIP
5 and do want to remind you that we are hoping that in any
6 process of any consideration of CHIP that we are hoping to
7 not take kids backwards, and the MOE has been a critical
8 part of maintaining high levels of coverage among children.
9 But I did want to touch on something with the
10 quality and some of the discussion around quality. The
11 Pediatric Quality Program was the first significant federal
12 investment in quality. A lot of quality measurement
13 development has been driven by the Medicare program, and
14 for obvious reasons, they have not focused on pediatrics.
15 And state reporting is a very big and important
16 component of that, but that's not the only piece of
17 quality. And quality funding needs to really encompass the
18 life cycle of quality measurement, which includes the
19 development of new measures, but it also includes the
20 endorsement of these measures because that is a very costly
21 process that needs to happen. It also includes the
22 stewardship of these measures.

1 So it really shouldn't be thought of in any terms
2 of one specific component but really should look at the
3 lifetime, and we'll follow up in more detail on that
4 aspect. Thank you very much.
5 MS. WHITENER: Hi. I'm Kelly Whitener with the
6 Georgetown Center for Children and Families, and thank you
7 all for the discussion today. I would like to reiterate
8 what some of the other commenters have already said that we
9 definitely support your discussion and consideration of a
10 longer-term CHIP extension. Five years-plus sounds great
11 to us.
12 On the MOE, I would like to just sort of go back
13 a little bit and think about exactly what it does cover.
14 There was a lot of discussion about eligibility levels,
15 and, of course, that's critical. But the language also has
16 provisions around the standards, methodologies, and
17 procedures that the states had in place. And that may be
18 some of what you're worried about and would like to have
19 the flexibility to change, but to put a finer point on what
20 that means, that's premiums. It's waiting periods, lockout
21 periods, waitlists, freezing programs, and capping
22 programs. So, to the point Andy made earlier, you could

1 see CHIP look very different without the MOE,
2 notwithstanding maintaining some higher level of coverage.
3 You could really see a lot of kids lose coverage because of
4 some of those other things.
5 Certainly, Arizona is the best example of what
6 happens without an MOE, and it wasn't pretty. Their
7 coverage levels for kids in the CHIP income range were the
8 lowest in the country, and we're very happy to see that as
9 of the 1st of this month, they have reopened CHIP.
10 That was very much linked to the bump, so
11 definitely appreciate that your conversation around the MOE
12 is thinking also about how it's connected to the federal
13 funding for the program.
14 But Arizona is not alone. Other states are
15 looking ahead at pretty dismal financial picture and
16 thinking about what they might do when the MOE goes away.
17 The most public example of that is in Oklahoma as part of
18 their budget rebalancing act to move all CHIP kids to the
19 marketplace.
20 So, despite a popularity in the program and a
21 real interest in covering kids, when states are looking at
22 their budgets and see that the marketplace is free to them

1 and that publicly it wasn't look like a loss of coverage,
2 it certainly wouldn't be covered that way other than by
3 people like us, but not on the nightly news. You would
4 really see a decline. I would just encourage you to think
5 about that.

6 I think also to think back about your own
7 principle on not going backwards and the work that you've
8 done to show that there's a real difference between CHIP
9 coverage and marketplace coverage, without the MOE, I think
10 you would be going backwards, so you would have to be
11 willing to overcome that principle or push that principle
12 aside in favor of some of the other principles you're
13 trying to balance in terms of state flexibility and others.

14 So my final point on the MOE is really that if
15 you think about the likelihood of some of the marketplace
16 changes that you have also discussed as really needing to
17 be foundational prior to any end of CHIP, such as fixing
18 family glitch, I don't think that's happening in the near
19 future. I think it's probably a very long way off for
20 political considerations and also because it's very
21 expensive to fix that and some of the other affordability
22 problems you've identified in the marketplace. So it's

1 just really unrealistic to expect that that's going to
2 happen quickly, so it kind of supports some of what Penny
3 had to say about being realistic on your timeline that may
4 be going a little bit longer.
5 And then, finally, you had some conversation
6 about increasing eligibility levels in Medicaid or CHIP,
7 and I would just encourage you to make sure that you
8 provide for that statutory flexibility in your
9 recommendations. Thank you.
10 MR. CROSS-CALL: Hi. Jesse Cross-Call, the
11 Center on Budget and Policy Priorities, and I want to echo
12 a lot of the comments that were just made about the MOE.
13 We believe that the MOE has been a big reason that kids'
14 coverage has continued to expand during this decade, and
15 we're really worried about incentives for state if you take
16 away the MOE. The examples from Arizona and Oklahoma, I
17 think really speak to that, that states are already eying
18 what happens in 2019 as a way to roll back eligibility
19 levels.
20 And then if the MOE goes away, it's not just a
21 question of whether those kids move into the exchange. The
22 fact is it's very likely many of them would become

1 uninsured, so just urge you to reconsider where you are on
2 the MOE right now. Thank you.
3 MS. FITZGERALD: Hi. Carrie Fitzgerald from
4 First Focus. I would also like to reiterate how happy we
5 were to hear you talk about five years and the longer
6 extension. We think that's very good for states, for
7 families, for providers, for planning. It's very, very
8 helpful for them.
9 As far as the MOE, this conversation was pretty
10 concerting and a little worrisome. I'd like to go back and
11 talk to some of my colleagues, and we'd like to send you
12 written comments on that issue. Thanks.
13 CHAIR ROSENBAUM: Thank you.
14 Well, seeing no more comments, we are adjourned
15 for the day.
16 * [Whereupon, at 4:36 p.m., the meeting was
17 adjourned.]