PUBLIC MEETING

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

Thursday, October 27, 2016
9:34 a.m.

COMMISSIONERS PRESENT:

SARA ROSENBAUM, JD, Chair
MARSHA GOLD, ScD, Vice Chair
BRIAN BURWELL
SHARON L. CARTE, MHS
ANDREA COHEN, JD
GUSTAVO CRUZ, DMD, MPH
TOBY DOUGLAS, MPP, MPH
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CHARLES MILLIGAN, JD, MPH
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PENNY THOMPSON, MPA
ALAN WEIL, JD, MPP

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:34 a.m.]

CHAIR ROSENBAUM: All right. I'm going to ask us to come together. Good morning, everybody. Welcome to the October MACPAC meeting, and we have a really busy and packed schedule today with a lot of important work, and so we're going to plunge right in. And the first thing on our agenda this morning is Children's Coverage Recommendation -- Remaining Decisions for the Commissioners: Part I. So this is a story we're telling in two parts or a session we're having in two parts. And as usual, of course, Joanne and Ben are going to lead us, so welcome and take it away.

CHILDREN'S COVERAGE RECOMMENDATIONS – REMAINING DECISIONS FOR COMMISSIONERS: PART I

* MS. JEE: Great. Thank you.

As you said, Sara, we're going to return to the topics of CHIP and children's coverage today, specifically to the remaining decisions on the design specifications for the recommendation package. We looking forward to hearing from you on these issues and questions as you continue to move forward to your December 2016 vote.

So we do have two sessions set aside today, and

during this morning's session, we'll do a very quick recap of where the Commission left off in September, and we will focus on the specifications, specifically on the CHIP funding renewal component of the recommendation package, and hope to hear from you on what you think that should look like in the actual recommendation language that we'll bring to you for a vote in December.

Then in the afternoon, we will move on to the remaining decision points on the components of the recommendation package. So on the slide, these are the first three sub-bullets under the afternoon session. Those are all familiar to you.

We also will spend some time talking about the offsets and what MACPAC will say about them in its final recommendation.

We'll close out the sessions with a brief summary of next steps, as we always do, and just one more point on sort of how the sessions are queued up. If this morning you all finish your discussion on the elements of the CHIP funding renewal, you know, we might have -- if there's extra time, we could move up some of the pieces from the afternoon discussion to the morning.

Okay. So here's the recap of the September meeting. In September, staff shared with you a straw man proposal for a CHIP funding renewal recommendation package, and that straw man had four components, which are listed on the slide. The first was an extension of CHIP funding; the second was the creation of a new state plan option for CHIP-financed exchange subsidies for CHIP-eligible children; the creation of new children's waivers to promote seamless coverage; and the extension of a set of expiring provisions which historically have gone along with CHIP renewals in the past.

Your discussion in September covered all of those pieces, but you did spend a good amount of time focused on the elements of the renewal which include the duration of the CHIP funding renewal, the maintenance of effort, or the MOE, and the CHIP matching rate.

Other key takeaways from the September meeting were that priorities for the Commission in whatever recommendation you ultimately will make are to ensure a stable source of coverage for low- and moderate-income children and to support states in the development of innovative approaches for seamless children's coverage and

really trying to find a recommendation package that puts those things into balance.

We also heard from several representatives of the child health advocacy and policy community, and several of them submitted comment letters after the meeting for your consideration, and we shared those with you prior to the meeting.

Generally, commenters supported a five-year funding renewal for CHIP and the extension of the MOE, or the maintenance of effort. They also supported the extension of the expiring provisions. They disagreed with the straw man on the early phase-out of the 23-point differential to the CHIP matching rate, and they thought that it should remain in place through fiscal year 2019, which is current law. We also spoke with CHIP directors, and they generally shared these views on the extension, MOE, and the funding.

One more point on the CHIP matching rate, which was that some in the advocacy community suggested that some other kind of bump or differential to the match rate might be considered after fiscal year 2019 once the current 23-point bump expires.

On the straw man components for the optional CHIP-financed subsidies and the new children's waivers for seamless coverage, the opinions were a little bit more mixed. We heard from advocates, concerns about where these things -- what this would mean for children's coverage, while some CHIP directors thought that their states would be interested in some of these new opportunities to innovate.

So we're going to dig in a little bit on the extension of CHIP funding and the remaining decision points, so this is a pretty brief slide. So, again, in September you touched on each of these three elements of the CHIP funding renewal. The straw man included a five-year renewal of CHIP funding through fiscal year 2022, and during the September discussion, Commissioners, you seemed to mostly be in agreement on this point. There was some discussion of both shorter and longer renewal periods, but overall, what we heard from you was an inclination towards the five years.

The straw man also would have permitted the CHIP maintenance of effort to expire after fiscal year 2019. Again, that's current law. During the discussion there

were some differing views on this by Commissioners. Some of you thought that the MOE should be extended to ensure that states do not reduce eligibility levels for CHIP or introduce barriers to obtaining or retaining that coverage. Others, though, thought that the MOE had been in place for a long time and that it was appropriate to return flexibility to the states for the management of their CHIP programs.

On the CHIP matching rate, the straw man recommended a phase-out of the 23-point bump differential to the CHIP match by fiscal year 2020. A few of you raised the possibility of considering a quicker phase-out than that, but some of you also stressed that if the requirements of the MOE were to stay in place, then the increase in the matching rate should stay in place as well.

So that is a very, very quick summary of where we left off in September, and the decisions for you today are: How long should the CHIP funding be extended? Should the MOE be permitted to expire after fiscal year 2019? And what should happen to the 23-percentage-point bump in the CHIP matching rate after fiscal year 2019?

That's it.

CHAIR ROSENBAUM: Thank you very much.

So I thought, since we have much to chew on here this morning, that the easiest way to kind of get us into the discussion would be if we had Peter and Penny kick us off with some discussion, and then we are just going to sort of move around the room to get some amplification on the points that are on the table.

COMMISSIONER SZILAGYI: Sure. Thanks very much. And, Joanne, thanks for a nice summary and all of the incredibly hard work that you and Chris and the entire team and Anne have done on children's coverage.

Having thought a lot about this since September, I kind of wanted to initially lay out a little bit of my rationale and my thinking, and hopefully this will sort of move our discussion. And I'm really excited and happy that the Commission is thinking about children's health in such depth, and I know you did way before I joined the Commission.

So, first, I want to say one statement that I've made many times before here. CHIP is a remarkable success. We don't often see this in evidence for remarkable success in health care. We should sort of celebrate this success.

And I've said it many times, but it's clear that children's coverage is better, not only coverage but the quality of care and health outcomes. So I think we just have to always, you know, remember that.

To me -- and I have said this before in public meetings, too -- as a physician it's sort of ingrained in my soul that if something is good, you do no harm. That doesn't mean not to tweak, but you do no harm. And so I have sort of that principle that I'm coming from.

At the same time there's really strong consensus in this Commission -- and I share it -- that coverage under separate CHIP authority isn't, you know, necessarily permanent for the next 100 years, and I really share that. And I'm really excited that the Commission is very interested in heading toward a really unified children's health insurance system for low-income children, however that would look, with seamless transitions between CHIP and Medicaid and the exchange, and so a really unified system.

I love the way I think Alan described it last time, that in a way CHIP is an important program now, it's also a bridge to a better health system. And I think that's just another very important principle to think

about.

So if other options on the exchange could offer comparable coverage, I don't think CHIP would be needed. But for years and years now, MACPAC has shown very good evidence that in no states are other options comparable and good for children. So we're in this situation of what to do about CHIP when the alternatives do not yet exist, and I kind of love, again, that bridge analogy. So that's why we're grappling with these three issues: the duration of extension, the maintenance of effort, and the matching rate. So let me sort of give my views about these three.

In September, I shared the view by I think the majority of the Commission for a five-year extension. I know we weighed the pros and cons for shorter or longer extension. I kind of feel that there is some evidence when we did a two-year extension that that didn't move forward the exchange, the alternatives. So I think we have to have some good evidence. So I would propose a five-year extension through fiscal year 2022. And at the same time, to me personally, this doesn't equate to saying that CHIP is permanent for the next 100 years. It's a five-year extension.

So the MOE, you know, I don't particularly love the concept of an MOE, and I really heard what other Commissioners were talking about in September, and earlier, about the fact that it reduces state flexibility and state innovation and CHIP is a state program. I think about the MOE as protection for children while the alternatives evolve. And until we find an alternative in each state that is comparable to CHIP, I see the MOE as protection for children. And by "comparable," I mean in terms of affordability and comprehensiveness of benefits.

So in my mind, as I think about this -- and I'm just putting out my rationale -- to me the MOE is intricately tied to the alternative. It's less intricately tied to a date, like 2019 or 2020. To me it's just -- it's tied to the alternative. If the alternatives would exists, then we shouldn't have an MOE. Until the alternatives exist, I personally feel that we should have an MOE. It's kind of like CHIP is a bridge, the MOE's the support structure for the bridge. Maybe that's five years. Maybe it's shorter than five years. Maybe it's five years for all states. Maybe it should vary across states if in some states the alternatives exist. So that's my feeling about

the MOE. It's intricately tied to the alternatives. If we could figure out if in a state the alternatives are good, then the MOE shouldn't exist.

So the matching rate, I do think that if we're hold states to the MOE, then we should have a very high federal matching rate, and I get that this is a cost to the federal budget, but I'm personally not tied to the exact 23 percent. We went from a median of 71 percent matching rate to a median of 94 percent matching rate if you average across all states.

So I don't know what's the right matching rate, but I kind of share that if we're tying states to the MOE, then we should have a very high matching rate.

I do want to put out there CHIP worked very well before the 23 percent enhanced matching rate. In all the states it worked very well. At the same time we have heard examples of after the matching rate, 23 percent bump came in, we have heard examples in some states of improved coverage for children and improved services for children.

So sort of tying it all together for me, I feel very strongly about the five-year extension and would have a difficult time supporting something shorter. I do feel

very strongly about tying the MOE in each state until good alternative coverage exists. I feel less strongly about whether that should be all states or perhaps -- you know, but I feel that it should be tied to the alternative. And I do support the enhanced match, but I'm flexible on the 23 percent because I don't see unbelievable evidence about what should be the right match, and I do think states have a very important stake in the game, and obviously the federal government. So that's sort of -- I don't know if that -- I hope that progresses the argument and provides at least my rationale.

CHAIR ROSENBAUM: Thank you.

COMMISSIONER THOMPSON: Thank you. That's a great way to kick us off, Peter, and I think I can be in agreement with you on every sentence of that.

I wanted to suggest perhaps some ideas around some of the elements that you mentioned. And, again, this is within the context of thinking about the last conversation in which for a variety of different reasons, I think we coalesced around the idea of wanting to provide a five-year extension. And so then that's what really, I think, creates this question about MOE and FMAP for that

long of a period. So what I would like to do is suggest that maybe we think of the five years -- there's a five-year extension, but think of it as being broken up into kind of two stages.

So the first stage is one in which we say status quo, MOE, and enhanced FMAP as we've known it. Certainly, at least I think, some of the letters we received and some of the conversations we had made a compelling case of just at least maintaining that at least through what current law provides and maybe adding another year. I don't know if we think of this as two and three or three and two, but that can be a point of conversation.

But then in the second phase we think about ways in which we can at least acknowledge that this is a long time for MOE, it's a long time to maintain the full enhanced match, are there some steps that we could be taking. I think reflecting, Peter, some of the principles that you just described. So I'm going to put three ideas on the table around that -- two related to MOE and one related to enhanced match -- and these are all with respect to that second stage that we're talking about, so whether it's the three -- it's after the three or after the two.

So one is the idea of an MOE off ramp, and an off ramp would be something that was built into the statute that would basically say if the conditions change that caused us to want to keep MOE, that there could be a way for a state to be relieved of its MOE responsibilities.

One of the mechanisms that we could recommend around that would be some kind of secretarial certification. And just to be clear, the changes that we're talking about could be changes in a market; they could be changes in an administration's policies or decisions, say, around pediatric benefits. They could be changes that Congress would make in law. And we don't know what the shape of any of those kinds of changes might be. We don't know what the impact of any or all of those changes might be in a particular market.

So the idea here would be that the Secretary would examine a market and certify that children's coverage is available, it's as accessible, affordable, and comprehensive as it would be under CHIP, and in so making that determination, would allow a state to be relieved of MOE in those circumstances. So it would be a very fact-based determination.

We'd probably have to recognize that that would take some level of resource or effort on the part of the Secretary, and so there may need to be some support for that from a resource standpoint for the Secretary to carry that out.

A second is that we've also -- we had a little bit of a discussion last time in the public meeting about what is MOE, because it's composed of various pieces, and likewise, it's possible that some states could receive some flexibility on some pieces of MOE, while otherwise maintaining -- "maintaining MOE" is a little bit of a redundant term, but otherwise adhering to MOE.

We've done, as MACPAC, a little work on some of the pieces of MOE. We've talked a little bit about waiting periods. We've talked a little bit about premiums. But we haven't done any kind of comprehensive evaluation of all the different components of MOE and what you might allow a state to change or not change without making a material impact on the level of children's coverage.

So, again, it occurred that maybe one of the things that we could call for is for the Secretary to examine the components of MOE and identify those pieces or

ranges of actions that would still -- would have a -- I don't know how to characterize whether it's it would not have a material impact or would not have a substantial impact on children's coverage but could still provide some maneuvering room for states and make those flexibilities available in that second stage, because we don't have all of the evidence or data to be able to say what that range of motion ought to be. And if we're not thinking that we want to provide any of those flexibilities for at least a couple more years, there's some time to call for some examination of that and a report on that for that to be then provided on an evidence basis.

And then, third, on enhanced match, I think we all recognize that what we're talking about here is the cost of the program is the cost of the program, and we're talking about how much the federal government takes versus what the state takes. I think we could make an argument. It's somewhat arbitrary when we talk about enhanced match. The strawman that we looked at last time was effectively saying, well, there's enhanced match, and then there is regular match, and those are kind of the two choices. And we want to march down from an enhanced match to a regular

match.

The other option -- and this was suggested in, I think, at least one or two of the letters that we received after our conversation last time -- was to find some middle ground between those -- or maybe not exactly middle, but some place between them. And I think, Peter, this is a little bit of what you are getting at about is the 23 percent a magical number. It just happens to be the number.

But I think that we could also recognize the impact on the federal budget and maybe a desire to restore some level of state contribution across all the states by taking some modest reduction from that enhanced match in that second stage, and you could do that a number of different ways. It may be that we would propose one but also acknowledge that there is various formulas or methodologies that you could consider around that.

One would be just taking 10 percent back from wherever the state was at year three, say, or four, and across the board, every state is reduced from their previous enhanced match by a common 10 percent. Another is to say the enhanced match continues but with a cap of 90

percent or 93 percent because that's the median.

So I think there are some places around there which would still in acknowledgement that even with the changes that I am suggesting around MOE, it's still a fairly limited range of motion for a state under either one of those situations, and because we want to maintain coverage, that we want to acknowledge the federal investment there. You can also make some arguments about other sources of coverage and other levels of federal match that would justify a certain point on that scale.

CHAIR ROSENBAUM: Thank you. You've given us a lot to chew on here.

Toby, can I ask you to jump in with any additional thoughts?

And then I think what we'll do is maybe just move right around the table.

COMMISSIONER DOUGLAS: Since the last meeting, I have been struggling on kind of where to go on this, given just a lot of my fellow Commissioners coming from different sides on it, and definitely, my perspective has been on kind of coming from a state flexibility perspective, which has been kind of hitting against the MOE, and then this

question on the FMAP, the five-year extension has always to me felt like we need five years. I felt from the last Commission meeting, there was a lot of agreement around that with these other two issues.

I like where Penny is going. I could support the concept of looking at ways to provide some flexibility on the MOE but really focused on preserving children's coverage and not impacting that underlying goal, as we look to where we go after the five years or up or sooner in terms of interactions with the exchange.

On the FMAP, there is no right answer on this. I think it is a very difficult question, but again, to the extent the MOE is in place, I really do, from a state perspective, think that the federal funding and the enhanced FMAP needs to be somewhat in line. Moving it down a little bit, as Penny suggested, would be, again, to me kind of threading the needle here on finding some right -- again, it's not scientific, but the right balance that I could support.

CHAIR ROSENBAUM: Thank you very much, Toby.

Gustavo, why don't we start with you.

COMMISSIONER CRUZ: Okay. Good morning.

CHAIR ROSENBAUM: Good morning.

COMMISSIONER CRUZ: Yes. Definitely, Penny and Peter have given us a lot to chew on and to think about. I have been thinking about this since the last meeting.

First of all, with the direction of the extension, I feel very strongly about the five years. I think we are, more or less, in consensus on this for many reasons. It will take a long time, as we know, for the Secretary and for the relevant agencies to sort of fix all the glitches. So it's the ultimate goal that should be a unified system of ensuring these children.

In terms of the MOE, I agree with both Penny and Peter. I see it as a protection of children. I see that we don't have all the pieces together in terms of the coverage of these children under the extension, as it refers to the essential benefits, to the issues of vision and dental, to the subsidies and many others.

My issue with -- or not really issue -- my concern about the flexibility of states is how many are known we have and how much we can sort of prescribe to the Secretary as to what are those flexibilities and what are sort of the right way of moving these children to the

exchanges.

We know how long it took the Secretary to sort of certify or not certify any of the exchange plans as to the similar in coverage to CHIP, so I'm not even sure that five years would be enough. Hopefully, that would be because that is our ultimate goal is to have a unified system of protecting these children.

So, as long as we can sort of be able to specify what the flexibility is, what that will entail, and make sure that the Secretary has the resources to do that, we could discuss these two, three years or the duration of the five years. I would be open to that discussion.

In terms of the matching rate, as Toby said, it is a very, sort of thin line. I think if the states are under the MOE, there should be some sort of matching rate. I have not seen any evidence that 23 percent is the ideal percent or what percent should be. So I think that's something that we can definitely discuss, and I'd be open to discussion.

CHAIR ROSENBAUM: Yes.

COMMISSIONER GORTON: So, at our last meeting, I was one of the voices that took what I guess is the

somewhat conservative stance that we should not extend the program for a long time.

With due respect to my colleagues about the emerging consensus, I want to just say on the record, I remain enormously uncomfortable with this concept of five years.

And I just want to speak briefly with an illustration to share with you why. My eldest grandchild was born in 2011 in a post-ACA world. His parents were graduate students, and so while they were covered by their parents' insurance, Jack was not. So he started out on Medicaid. His dad graduated, got a job, and happily, Jack no longer qualified for Medicaid. The state was very good at terminating his Medicaid eligibility and a lot slower in affording him CHIP coverage, but it came eventually. But, still, he was uninsured for a period of several months during a critical period of his infancy. Happily, we have the means to make sure he got care in the meantime. Ultimately, his dad was able to afford employer-sponsored coverage, and by the time his brothers were born, the family was able to purchase family coverage.

Now, we're not talking about a child in inner-

city poverty. We're talking about a child of the suburban professional elite, and in the space of his very short life, he worked his way through all four of the options that we use to coverage children. Some people are not so fortunate. They get stuck in one or another, and while I agree with Peter that the CHIP program, for the people who actually get into it and who are certified, has been a success, there are an awful lot of people who can't get into the program.

The White House Council of Economic Advisors released numbers last week that suggested that in addition to some of the bump we've seen in CHIP in the last couple years, we've had 1.4 million children enroll on the exchanges. This Commission has been very vocal about how inadequate that coverage is, and my concern is that as long as CHIP is part of the fabric and creates air cover for all of us to feel very noble and proud about what we've done for children's coverage, then the kids who are uninsured, the kids who straddle the chasm, the families that are covered by three and four different coverage packages, those people are sort of left with an unmanageable and, I think, not good situation.

So, for me to just say five years, five years, five years, let's just continue, that is going to allow the next two Congresses and the next presidential administration essentially to take a walk if they want, and four years from now, five years from now, we'll be no better off.

So I have been a proponent for calling the question. It is true that in the last two years, people have done precious little, and I think that's shameful, quite honestly, but I do think that we need to begin in some way to draw a line in the sand.

As Penny has suggested, it doesn't have to be five years in a lump, and I guess if the recommendation were framed appropriately so that the first period -- two years or three years -- I like two because that lines up with the Congress -- that there was a call to action to say, "Congress and the administration, you got to work on this." The next Congress should put pencils to paper and try and figure this out so that the subsequent three-year period is the implementation period.

I get that states need a planning horizon. I get that to the extent we are using exchanges, the managed care

organizations need a planning horizon. Everybody needs some stability, and so I would be able to get behind a recommendation that said, "Okay. It's five years, but it's two years to enact the successor program and three years to implement the successor program with the necessary off ramps," and then CHIP should go away, because I remind everybody that by 2022, we will be 25 years into this temporary program. We will have parents who were born into and grew up on CHIP now enrolling their children in CHIP, and the longer that this temporary program continues, the more it gets woven into the fabric of how we do health care in this country and I think the harder it gets to undo.

For me, it is time to draw a line under CHIP for all of its successes, and we ought to feel proud. Peter is right. We ought to feel proud at how successful we have made the program, but it's time to regularize children's coverage across the economic spectrum to give the states the flexibility to build programs to serve their child populations so that kids don't fall in and out.

With respect to the maintenance of effort, I think the maintenance of effort has gone on too long. The world is a different place, and so I would be supportive of

what Penny has outlined in terms of some sort of off ramp, particularly to the extent, as we're going to talk about this afternoon, if there's some sort of waiver that allows states to create seamless children's coverage, then that ought to be a way to get out of the MOU. And I think that that's important.

I would tend to say, you continue the MOU until such point as the successor program is in place in a given market and a given state, and then you relax it -- MOE. I'm sorry.

With respect to the matching rate, here I just -- this 23 percent was never necessary, and with due respect to my colleagues, it was already 74 percent. It was already a substantially federal program. The 23 percent has been out there. The MOE was in place long before the 23 percent came into effect. So I personally do not find that linking those two is a compelling argument. The states were toddling along and doing okay without it.

I am bothered by the fact that the 23 percent just goes into the general fund of the states and is appropriated as the state legislatures see fit. That 23 percent moves money from one state to another. The states

who are paying the money and the taxpayers in both the state and the federal who are paying the money have no control over how the receiving states spend that money. I don't think that's prudent fiscal policy.

It's a big chunk of money. For the period we're talking about, it's north of $10 billion, and I think Congress should do the work of saying how that $10 billion should be spent. There are roads that need to be fixed. There are educational issues that need to be dealt with. We have homeland security issues that need to be dealt with. There are other children's issues in terms of food security and housing stability and other things that need to be dealt with, and I just really can't support five more years of just give them the 23 percent: one, because it makes it essentially a federal program, which I don't think it should be; and two, because we haven't appropriately appropriated the funding for an impactful purpose.

So I would be inclined -- I would feel much more comfortable supporting the five years if we could step down the enhanced matching rate fairly abruptly along the lines of what we put in the straw model last time. One, I think that helps us create the offsets -- it's not an offset

because it's already baked in, but it helps us create the financial bandwidth to be able to extent the program we're talking about. And, two, I just think the money needs to be appropriate by the Congress for particular purposes, and I'm simply not comfortable just sending it out to the states.

CHAIR ROSENBAUM: Thank you very much.

Stacey.

COMMISSIONER LAMPKIN: Thanks. So with respect to duration, I was one of the crew last time that was fine with five years on the logic of some of the experimentation that we thought might be able to happen if we didn't have congressional movement to fix some of the issues. And so trying to balance those considerations, yes, we'd love to get a quick fix. But if we can't and we want to give the states the ability to experiment a little bit, we need to give them enough time to practically draw those experiments up and implement them. And I think that's still my thinking about the duration, as we've talked and as I've listened to others, that we want to strike that balance.

With respect to the MOE, I was last month coming at this very much from a federal-state program, state

flexibility perspective similar to what Toby said. But I understand the concern about losing ground and what, as I've listened to others, I find persuasive is the bridge analogy. And, Peter's very eloquent comment about MOE relating perhaps more to alternatives than a particular date in time.

So I'm fairly persuaded along those lines that if CHIP really should be temporary, it is a bridge to a more coherent, systematic approach to children's health care -- I'm not as eloquent as Peter was -- but then maybe an MOE makes more sense and I can get to a place where that is acceptable.

And a two-stage MOE feels even better to me because that's allowing for potential more flexibility as alternatives develop, so that makes a ton of sense. So I'm supportive of that idea.

I do have a question for Penny in terms of the things that -- the three ideas on the table and the second stage that you were proposing. Would they all three -- would both the off ramp and the separate components of MOE -- are you proposing both of those, or is it one or the other?

COMMISSIONER THOMPSON: I was suggesting both, so I was suggesting one is very specific to an individual state, and, you know, we could talk about whether or not the Secretary affirmatively goes out on her own to evaluate these markets and just does it on a regular basis and provides that information, or whether it's done after a state requests that because they might be interested and they might believe that their market is such that it could meet the requirements.

But that's a very state-specific assessment, versus the MOE component evaluation, if we'll call it that, that I'm suggesting the Secretary undertake is more about a national policy that would apply to all the states to say we're going to give you a little bit more room on these components of MOE, so that states wouldn't be in a position to have to ask if they could do it. The Secretary would be kind of more proactively saying these are some steps that you could take if you wish. And it would be something that would apply nationally.

COMMISSIONER LAMPKIN: Thanks. So that sounds really appealing to me and striking the right balance and giving the states the ability to move when it makes sense

for them to be able to without losing ground. So it gets us to that sweet spot.

The matching rate is harder because I definitely hear Kit's comments about it, but from that federal-state program, to the extent that you're reducing a state's flexibility, giving something in return makes sense as well. And so I have a question for Joanne and Ben on this. When you talked to the -- you told us a little bit about the feedback. We saw letters. But when you talked to the CHIP directors, did the CHIP directors find that there was a linkage or find the linkage between the MOE and the enhanced FMAP important?

MS. JEE: So when it was a small -- it was like 20 or so CHIP directors, and what we heard from them was that overall CHIP was, you know, widely supported in their states. So, on the one hand, they sort of foresaw that it would be hard for them to sort of take away children's coverage. But, on the other hand, you know, if there was a change in the matching rate, then I think one of the CHIP directors said, "Well, that would maybe force us to have the conversation on what to do with the CHIP eligibility levels."

So, you know, some seemed to sort of tie it together, but I don't think that anybody was super definitive on that point.

COMMISSIONER LAMPKIN: Okay. And when we get to Sharon -- Sharon, if you feel like you can?

COMMISSIONER CARTE: Yeah, I was at the meeting, and I want to say, first of all, that I appreciate that the Commission staff took the time to meet with the CHIP directors and hear them out. And, Joanne, maybe because -- I am a CHIP director in a state that has some severe budget challenges, but I thought that I heard several directors say that they were concerned that, without the maintenance of effort, they would be put in a much more difficult position. And regarding that, I'd just ask all of you to look at the matching rate where it currently stands with the bump, and it does sound like, you know, with over a dozen states at 100 percent or 99, that that's a generous or cushy place to be. But when you look at those states, a number of them are the energy states that are suffering deficits right now, and you just -- I don't think we're going to see a quick snapback from that.

Also, as a long-tenured CHIP director, I just

remember in years past where states like North Carolina or Florida rolled back their CHIP benefit or enrollment, that they had waiting lists, and then they subsequently reversed that when economic times were better. It just goes to Peter's point that, you know, we can't expect that states will just sit by when they're experiencing the difficult challenge of having to balance their budget.

COMMISSIONER LAMPKIN: So I'm still not exactly sure where I end up on this one. I'm torn between the two arguments, honestly. I could see some reduction from the 23 percent, and it feels like it would almost be arbitrary, though, to pick what that number is. And others have made that comment.

CHAIR ROSENBAUM: Thank you.

COMMISSIONER GEORGE: Well, as many of you know, I am the parent on the Commission who has a child on the CHIP program, and my biggest concern is when I consider working families, with where the ACA is now, with where health insurance premiums are going up for my family, that we're paying out-of-pocket. Part of me says, you know, maintenance of effort, I agree with Kit, it has been on for a long time. Part of me is like, yeah, this gives more

control back to the states. The other part is like, well, what's going to happen to my kid and every other child out there that, you know, whose family -- okay, Mom's a stay-at-home Mom taking care of the younger ones, Dad's working, we're paying spouse and employee coverage on his health insurance plan, it's coming out to about 15 percent of our annual income just to pay for the premiums, not anything else.

So how do we pull all that together? And, you know, it boils down to that maintenance of effort. That's the tricky part as far as that minimum threshold, as I shared a few minutes ago.

Duration of the extension, right now there's so much going on in Congress, in this election, so much uncertainty, me as just the Average Joe parent, you know, facing all these things. And I'm like, you know, if this person's elected, what's going to happen to the entire system? Are we going -- you know, if this person's elected, how are we going to improve this part of the system? And so there are so many different concerns there.

My biggest thing is that the matching rate -- I think the 23 percent bump is really, really high. When I

look at the charts, I'm seeing at some stages we're getting 100 percent coverage from the federal government. That is, you know -- and some of the states have tried to save money to better provide more services for a more economical way of doing it, because, I mean, I have to balance my budget, most of the states have a balanced budget. But what's the incentive for them to be as cost-effective as they can be there?

I like what Penny had suggested about setting a maximum threshold, up to like, say, 95 percent, because some states, you know, it's really, really challenging.

As far as duration of the extension, right now because of so much uncertainty I'm for five-years because there is that much uncertainty, and as a common parent person, I don't really know what's going to happen in six months. I don't think any of us do, though.

CHAIR ROSENBAUM: Thank you.

COMMISSIONER MILLIGAN: Thank you. Sounds like I missed a fun meeting in September.

[Laughter.]

COMMISSIONER MILLIGAN: So I have, I think, several points I wanted to make. I have really enjoyed

listening to my fellow Commissioners and learning from them and having my own thoughts evolve based on the comments. So let me try to provide some feedback about where I could land in terms of an eventual recommendation from the Commission.

I could support the five-year duration. In a minute I will also say that I support more of this two-step version, but I can support a five-year duration.

My starting point with a lot of this is I was the New Mexico state Medicaid director when CHIP was passed. I was asked to start the CHIP program in New Mexico coming out of the BBA in all of the late '90s. And a little bit of context that informs my thinking about this.

At the time CHIP was a great bipartisan compromise piece of legislation to serve children, but it was very much in the aftermath of the sort of all of the controversies associated with the Clinton health plan and the kind of failure of a more comprehensive health insurance model, and CHIP became then a coverage expansion that could achieve bipartisan support. But in my view of it, my lived experience was that it was a way of trying to get coverage expansion in the aftermath of a failure to do

it more comprehensively.

When CHIP was created, every state's starting point for CHIP was based on where that state's Medicaid coverage at the time was for kids, because Congress didn't want to substitute enhanced CHIP funding at the time for lower Medicaid funding and just have states basically maintain a status quo Medicaid coverage level and swap out the enhanced CHIP funding for Medicaid funding as, you know, a federal financial substitution but actual no coverage expansion. So every state had to go up a percent of federal poverty level from its starting point with Medicaid at the time the BBA was passed.

And to me, the reason I'm going into this is where that has resulted to even today is CHIP is very disparate state by state in terms of who it covers and what percentage of poverty it covers and what the benefit package is. I'm supportive of the different CHIP models about Medicaid expansion or Medicaid lookalike or non-Medicaid. But what we have is a situation where if you're at 210 percent of the federal poverty level as a family, your kids' access to CHIP is totally dependent on what state you're in, and that's totally dependent on where your

state's Medicaid program was in the '90s.

And so to me, one of my ongoing concerns about CHIP as a program going forward is the disparate treatment of kids based on their poverty level based on where they live. And so I continue to believe that the Affordable Care Act framework where every state has the same definition of household income under the modified adjusted gross income rules, how that applies to affordable tax commercial real estate in exchanges or cost-sharing reductions in exchanges, how it applies to Medicaid, that framework is the best framework for equity among families in the country.

And where that takes me is I continue to believe that the Affordable Care Act fixes that MACPAC has discussed in the past is the preferred approach to adjust children's health needs and children's health insurance, the family glitch, the absence of meaningful pediatric dental coverage, and so on.

So I do support five years, but I hope that those ACA-based issues get addressed to provide improvements in children's health coverage that will reach kids who do not have access to CHIP today, because a kid at 210 percent of

poverty should benefit regardless of where they live by addressing to me a more comprehensive approach, which was the precursor to where CHIP came from.

And if the Commission moves in the direction of a five-year duration recommendation, I can support that. I do hope that fixes to the ACA get done that would help kids' coverage in exchanges. And I hope that, you know, the back-end years of that five years could potentially be repealed. I mean, quite honestly -- I mean, I'm supportive of five years, but if there's a better solution that comes along that has appropriate transition time for everybody involved, I would love to see that outcome.

In terms of MOE and matching rate, enhanced matching rate, I want to sort of talk about this in sort of a combination. I do like, as Penny described it, kind of the two-step approach, and I'm kind of agnostic about whether it's two years plus three or three years plus two. I tend to think that the MOE and enhanced match rate should apply to the first part of that, that sort of staging, and not apply to the back-end part of that staging so that it wouldn't be an MOE and wouldn't be enhanced match rate for the entire five years. That's what I would be most

supportive of in a recommendation.

And I do think that those time frames for the MOE and the enhanced match ought to be co-extensive, because I do think that the limiting state flexibility -- and I want to talk about this in a second, but limiting state flexibility and the enhanced match rate to me are at a principal level linked concepts. I'll come back to that in a second.

I'm more dubious, honestly, Penny, about the flexibility as granted by the Secretary or CMS because states have heard that before and seen that flexibility is in the eye of the beholder, and so the ramp part I'm more nervous about in terms of anything that depends on Secretary approval of state flexibility, because we've seen in the past that something that meets the four corners of flexibility is, nevertheless, denied because of different policy visions as between the federal government and state governments.

A couple of other points and then I'll stop. I'm aware that the recommendation that we're talking about costs federal money, both the duration and the MOE enhanced match. I do think that we should have a conversation to be

good stewards of fiscal funding and be prepared to say that there ought to be offsets and there ought to be pay-fors, because I do believe that. So I wanted just to say that piece for now.

In terms of the state flexibility part, the MOE, and the matching rate, the point I really want to make is state flexibility as a concept, here's what that means to me in reality. If states are obligated to provide coverage because of an MOE and the enhanced match rate is reduced or goes away, what the effect of that is, is to force states to appropriate state funding that otherwise would be used for other purposes at the state level, whether it's K-12 education, higher education, infrastructure development, public safety, whatever the case may be. And I know that our scope is really Medicaid and CHIP and our scope is really health insurance programs. But where the rubber hits the road at the local level, if you have an MOE imposed on a state and you don't provide enhanced match rates, this concept of state flexibility is kind of, you know, a generic buzz word, perhaps. But the reality is you're forcing state governments to make choices that could have as unintended consequences higher class sizes K-12,

higher tuition rates at higher ed., roads that don't get repaired, bridges that don't get repaired, like real bridges. And so I think that that's to me why the MOE and the enhanced match are linked concepts.

I will say -- and I think this might be my last comment -- I'm more confident that states actually, if the MOE did not exist, would nevertheless not reduce kids' coverage, and that CHIP as we knew it, before the 23 percent bump, which was supported by all states and placed in all states, I'm more confident, I think, maybe than others that states will continue to keep those coverage levels, because at the state level, children's advocacy groups are strong. Pediatric hospitals are strong. Legal aid is strong. And state policymakers who work in state health departments and in governors' offices and state legislatures, state and legislative staff, support kids' coverage.

And so I think that I'm less cynical, perhaps, than maybe others about needing the MOE to force states to do the right thing by way of kids' coverage because I think that that would continue as it did pre-23 percent bump.

So let me just sum up this way. Duration, I'm

supportive of five years. I hope five years aren't necessary and the ACA fixes get addressed. I am supportive of the more two-plus-three or three-plus-two version of the MOE and enhanced match. I think we should be prepared to go on the record as saying that there should be offsets. That would pay for what we're talking about.

And I'll stop there. Thank you.

CHAIR ROSENBAUM: Thank you, Chuck.

Sharon.

COMMISSIONER CARTE: Earlier, I spoke a little bit about the MOE, but I'd just like to say on the question of extension, I think that the five years needs to be a minimum. When we just look at the tricyclic timing around federal and state budgets, the exchange rate setting that occurs, usually six months prior, before decisions are made about federal budget, the time that it takes to evaluate or assess evidence from any changes, I just feel that looking at the ACA, taking three years for the states to ramp up to implement, now we're three years along, three years would be a minimum, I would think, at which we'd even be ready to look at and see if changes have been made.

Again, the economy seems to be moving so slowly

at this point. I just don't feel hopeful. So I would see a five-year extension as a minimum and probably longer, but like most Commissioners, I think I could certainly support five years.

On the question of MOE, I don't know if I said this earlier, but at the same time that the CHIP has the bump, many states are now facing a decrease in their Medicaid FMAP, which is a much greater challenge than a small CHIP program.

Lastly, I would agree with some of the Commissioners that while MOE and FMAP are linked strongly, there has to come a point, though, where states need to be challenged to see if they're going to support their CHIP programs, and I just don't think it's realistic that the Congress is going to allow us to stay at a 23 percent bump forever. So I think a decrease in FMAP at a certain point is called for.

CHAIR ROSENBAUM: Andy.

COMMISSIONER COHEN: Thanks for all the thoughtful comments of my colleagues. I will try to be quick.

With respect to the duration of the extension,

like so many others have said, I'd prefer that we could say that a shorter period of time would be appropriate, but I don't think, unfortunately, that it is. If Congress makes a different decision on what the future of children's health coverage will look like sooner than five years, of course, then we'll do that, and the five years will be irrelevant. But I don't think you can play “chicken” with children's coverage, and I am nervous that a shorter-than-five-year time frame will just mean that this issue will come back. And soon it starts to feel a lot like a "I kicked the can down the road" conversation rather than a really thoughtful progression towards something. So I think a one-time five-year extension is appropriate.

On the maintenance of effort, at the last meeting, I shared Kit's concern. I think maintenance of effort is a really blunt instrument, and on the other hand, I think it has a good purpose under the circumstances, which is to -- you know, where the rest of the country has kind of moved forward with respect to coverage really for adults, it is an odd time to allow flexibility, which is an important value, but nonetheless, state flexibility is really only relevant for children's coverage at this point,

other than for the adult under 100 percent of Medicaid issue, and to allow potentially serious backward marching with respect to children's coverage.

So I very much like Penny's idea of trying to get to sort of the essential elements of the MOE for purposes of maintaining rates of coverage but allowing for the fact that 10 years is an incredibly long time to lock policies and procedures in place. Technology has happened. New processes have happened. People have had new ideas. There is new potential to work across agencies and share data. I mean, I just really hate the idea of, like, us totally locking some potentially very old-fashioned things in because of the blunt nature of an MOE.

So I like Penny's idea. I am comfortable giving the Secretary the authority to do a fact-based review. I understand Chuck's concern, but I think that's really sort of -- I think that's the compromise that I can live with. And I think we can give some real guidance to the Secretary that our concern is around rates of coverage and not reducing that in a material way.

I actually think -- I'm a lawyer. I think the words really matter. I'm not sure "material" is not quite

the right word, but I think "substantial" is actually too loose a word. So I think that's something if we coalesce around this concept, finding just that right word of the amount of slippage in children's coverage, that we would want the Secretary to be able to allow is actually an important discussion and an important word for us to think about. But I like the concept very, very much.

With respect to the matching rate, like so many of us, I find this a really difficult issue, one that as a Commission, we don't have a lot of tools to really -- and evidence to really work on.

I like the idea of thinking about a two-phased approach and tying the maintenance of effort with the continuation of this higher matching rate. Actually, I don't like it. I can live with it.

And I'm really concerned about the cost of this, of maintaining this bump and turning CHIP into having, in some ways, the disadvantages of a federal program, like the federal government pays for it without the advantages of uniformity and other things. So I also would be inclined to reduce the match over time and allow states to plan for that.

And that's where I am.

CHAIR ROSENBAUM: Sheldon.

COMMISSIONER RETCHIN: Well, I'm with you guys.

[Laughter.]

COMMISSIONER RETCHIN: So I guess, as I listened to the discussion, to me there's a little, I guess, tension between two different frameworks. One is what we recommend in terms of fiscal stewardship, and then I hear and certainly sympathize with the impatience of the CHIP program being incremental reform versus a more comprehensive approach to health care.

I don't understand on the latter the impatience for comprehensive health care reform. The notion that we would recommend constraining the extension of CHIP, to me that's a "Blazing Saddles" argument, "Don't come any closer or I'll shoot," sort of forcing Congress and states to adopt more comprehensive health care reform and "We'll show you. We'll stop CHIP." That makes no sense to me.

So I think it's a much more compelling argument that right now we are faced with, in a sense, I'll say the failure of the marketplace or exchanges, lots of uncertainty ahead, that I'm certainly for extending CHIP

for the full five years.

On the MOE -- and I loved the Freudian slip of the MOU that Kit was talking about.

[Laughter.]

COMMISSIONER RETCHIN: The MOE and the FMAP arguments, I get a little more, I guess, uncomfortable. I am very sensitive to Chuck's argument that this is basically a balloon at the state level, recognizing that the states -- somewhere between 43 and 49 states have balanced budget requirements, and if you really add it all up, it's virtually all states do. So there are always compromises there in terms of the obligations of states to fund different programs.

That said, what I am a little less comfortable with is an FMAP that continues indefinitely, and that's why I don't really understand why on the FMAP issue, we're not somehow or another looking at economic indexing. A flat decrease or a sustenance indefinitely, neither of those makes sense to me. It seems to me that we should be tying this, indexing it to unemployment or some ratio for the future, so that we can blunt the economic cycles that states are faced with where they have to balance budgets.

But, on the other hand, the feds should not continue the FMAP indefinitely, and I hadn't hear much discussion on that.

Lastly, on the relationship of MOE to FMAP, if we do choose to continue the FMAP with a bump, it also doesn't make any sense to me not to tie that to MOE, and I'm not suggesting the states might be using these general funds for the wrong reasons, but some, I would assume, feed rainy day funds and in some cases if there's no tying them.

So that's where I'm at.

CHAIR ROSENBAUM: Thank you.

Alan.

COMMISSIONER WEIL: Well, if Sheldon is with you guys, I'm with Sheldon, except when I think of "Blazing Saddles," I think we don't need no stinking badges. I don't think about gun to the head.

[Laughter.]

COMMISSIONER WEIL: And maybe that's also appropriate for where we are.

I have learned a lot from my colleagues here, and my thinking of this, around this has evolved as a result of the really high-level conversation.

I would just say, going back to Peter, I am not sure we all totally share a vision, but our vision of more seamless coverage, more equitable coverage, Chuck's point about equity across states, I would just add that half of the kids have private non-exchange, non-Medicaid, non-CHIP coverage, and equity in terms of what coverage means for that group is as important as well. And the child focus of CHIP and Medicaid is something that we really ought to proliferate, not just in the exchange, but in commercial coverage in general.

I support -- I don't know if I am the one who said it, but the bridge metaphor, virtual as it may be, is where I am stuck, which is that until we know what we're going to do that's better, I don't see how we can dismantle what we have.

And just with respect to Sheldon's last point, I mean, I think the challenge with shortening the timeline is that the changes that have to be made to achieve the vision that we often discuss are not internal to CHIP. So it's one thing to say we need to have this discussion again in two years or three years. The discussion we need to have is about the broader coverage environment, and forcing

another conversation around CHIP reauthorization, I don't think will move that forward.

I am struck by -- I wasn't a member of the Commission when you all did the two-year, and I think it was reasonable to imagine that the environment would change in the two years. We have now seen how slowly things change.

I also want to just reflect on the kinds of evidence that can only accrue over a period of time. For example, we knew right away that states' decisions whether or not to expand Medicaid would affect coverage, but we also now know that it affects the risk pool in the exchange. We wouldn't have known that up front, and that affects affordability and what we can do.

We've had the whole -- a term that I was only introduced to belatedly -- the "grandmothering" of the noncompliance small group plans. That will come -- if you want it, you can keep it, provisions at the state level. That's affecting risk pools.

So there's a lot going on that is just taking longer than we thought, and so while I like the idea of moving as quickly as possible to an alternative model, I am

a realist. And so, with respect to the questions we've been asked to address, I think a five-year funding period is appropriate. I would love for us to fix the problems faster, but I don't see any advantage in the uncertainty created by a shorter period.

I believe that the maintenance of effort should be preserved for the entire period, and I think having a high match rate may be a nice incentive for states, but it's not a substitute for an MOE. If we believe that coverage should be maintained, then coverage should be maintained. If we want to support states fiscally, we should support states fiscally, but one does not equal the other.

I agree with Chuck that cutting back on the match during a time of MOE just creates internal budget problems for states, and so while I share the view stated by others that I think it may be that Congress went too high in some states with their bump, I don't think while you sustain an MOE, you can pull back the match rate. So I would keep the MOE and the match rate for the duration.

Conceptually, I'm in line with Penny in terms of rethinking some of this. This ties, then, some into the

waiver discussion, which we sort of have at a later time.

My last thought to sort of foreshadow where I come out on that is that while I agree with the general notion of trying to open up some of these strictures to create some flexibility, I also agree that states have heard this story before.

I'm just struck by the fact that more than half the states have fewer than 5 percent of their kids without health insurance, and that if we're going to try to be creative, let's be really creative. Let's encourage some real creativity about realigning program eligibility, and I don't think, again, a tweak to MOE is the kind of creativity I would hope we could get to. If we're in the low single digits of uninsured kids in so many states, let's really fundamentally rethink the design of coverage, and that's where I'd rather put my energy.

COMMISSIONER BURWELL: I will be really fast. I agree with my fellow Commissioners who are pessimistic about moving to more comprehensive reform over a short period of time, and I don't think whether we extend for two years or five years is going to have any impact on that whatsoever, so I support a five-year extension.

On the MOE, I am more mixed. I am open to some kind of compromised position on the maintenance of effort. I tend to think that moving the politics from the federal level to the state level is a good thing, and because this is such a successful program, I share Chuck's optimism that states will not cut back on this program if the maintenance of effort goes along.

I feel most strongly about the enhanced FMAP. I think it was a temporary bump. It should be treated as a temporary bump, not a permanent bump, and we should go back to the regular CHIP rate over the five years, somehow.

Again, I am fairly optimistic that those two things -- the maintenance of effort and the reduction in the FMAP -- will not negatively impact children's health insurance coverage because I think states will keep the program and will fund it.

CHAIR ROSENBAUM: Marsha.

VICE CHAIR GOLD: Like everyone else, I'm impressed with the thoughtfulness of the comments of my Commissioners and also, Peter, your eloquent statement starting it off of values. I think I agree with those.

I'm in the five-year camp. I think it seems like

given all the uncertainty -- and we've heard this from states -- they really need a longer horizon. I can't see things happening that much faster.

I certainly am also in favor of a transition ultimately, so I don't mind us encouraging Congress to act to get rid of some of those barriers that have made it harder for the ACA to have the more comparable coverage to CHIP.

Maintenance of effort is just a rough one for me. I think I'm probably going to be flexible and be able to go with the majority of people here on that. I think it's facile to think that if you don't have it, it won't have an effect. I think these things tend to have an effect at the margins, and it's important.

I like the idea of the off ramp. I share some of Chuck's concern for administrative feasibility. I would be happier -- well, one is I think your idea, Penny, of tying money to it and administrative cost is absolutely essential because CMS doesn't have the resources. So if we do it, we should do that, and I would think they shouldn't look at every state but wait until states ask for it.

One way of doing that is to maybe tie it to some

innovation that would actually do things. And I guess I'm more concerned, given the state variability, I think one of the things that is a concern here is, you know, there's this so we give states flexibility, but there's also a sense that nationwide there should be some floor or some uniformity to children's coverage. And so the maintenance of effort to me is a concern, particularly at the lower than the most higher income. I mean, a state that goes to 400, you know, give them a little bit more leeway maybe than one that is under 250. But I'm okay, you know, with an off ramp if we give money. I'm just not sure that's a solution.

The matching is where I do have some concerns, and I think potentially there's some evidence-based ways -- I mean, essentially there's two ways to set matches. You set it uniformly across the country, which is what they did with the ACA. It was 100 percent. It's going to go down to 90. Or you base it on some criteria. Medicaid and CHIP are based on state capacity, and there's sort of a minimum, and then it's allowed to go up for states that have less capacity. CHIP by design is a higher federal contribution because it's viewed as important. So those things we know.

When I looked at the data on where the bump gets to, I do think it's important that states have some skin in the game if it's going to be a federal-state program. And so it seems to me that sort of setting -- you know, moving it down to 90 percent or the average, which is 92 or 93 or something like that, makes sense. Whether that's a uniform or it's a ceiling, I don't know. But it seems like maybe in the later years you go there. And my reason for saying that is more important, I think especially if you look at a three-two split or something over time as things change, if we're encouraging states to do -- or not encouraging but hoping that, if they want to, they'll take advantage of the exchange and try and experiment with ways of making it work. It's going to take money to make those benefits more comparable. And this is, again, the discussion in the afternoon, but absent a more uniform national solution to the problem, it seems to me CHIP is where the money's going to have to come from for doing it.

And so I think the enhanced match, when Anne provided me some data with, you know, what the average premium is for CHIP now and we don't quite know what it

would cost to buy -- excuse me, the average for the exchange, and we don't know what it would cost to buy in, but that match gives states some flexibility to create more buy-in than it would without it.

So it seems to me we can be on somewhat more solid ground in changing it, particularly in the later years. I still think it's probably important to keep it high, mainly for the transition idea, and allowing there to be some resources that could go into making the coverage more comparable absent some federal policy, which then makes it easier to come behind and just supplement whatever the feds do on the exchange.

CHAIR ROSENBAUM: Just a few thoughts.

I very much associate myself on this with Chuck and Kit. I feel that the greatest weakness for me in CHIP is that it doesn't give enough help to children. We're seeing that play out now in the discussion, in fact, around the tax subsidies in the exchange. That's what tends to get all the attention. But, in fact, equally, you know, the numbers are just too low in CHIP, and the program was never set up to be child health policy. It was set up, as Chuck points out, as an incremental -- good, small

increment to help a slice of children, and what we've learned by now is that we need to help a lot more children.

That being said, I also, of course, appreciate deeply what Peter said, that the fact that we need to do more -- or maybe this is Sheldon's "Blazing Saddles," still trying to decide can we put "Blazing Saddles" in the recommendation to Congress. But in the "Blazing Saddles" analogy, you know, why would we ever take something away from lower-income children in a short period of time because we think that the benefit -- the program should help higher-income children or lesser-low-income children?

And so certainly knowing just how complex the path is that lies ahead of Congress in fixing the big picture at this point of affordable coverage for all Americans, I associate myself with everybody and say, you know, we've got to have a five-year rule.

On the maintenance-of-effort provision, I very much like Penny's characterization of two stages, and I would make it a three-two for the simple reason that I believe that the policy development that's going to be needed to decide what the last two years would look like will need a rulemaking. It will need a rulemaking to make

sure that it is an open process where there is a formal opportunity to weigh in on the standards that should be applied in relaxing maintenance of effort. And knowing what goes into a rulemaking, I would think, and knowing that it's going to take some months for all of this to -- if our recommendations were to be translated into law, all of that will take time, that I would recommend strongly that we go with a three-two split to allow a very open and transparent process on what I would call the liberalization of a maintenance-of-effort standard.

For what it's worth -- I mean, this is where rulemaking, you know, comes in handy -- I think what we would want are a couple of things. One is, of course, general guidance for states on what is meant by liberalized maintenance of effort. But I also really liked Penny's idea of states being able to come forward and ask for an altered standard on the ground that they have what I would call an equally effective successor program. And the nice thing about insurance, some things, you know, in health care quality, it's a little hard to know what's equally effective. But insurance, I think we actually do have some relatively objective measures -- affordability, scope of

benefits, and actuarial value. I mean, I think we have a sense of what that means to have an equally effective successor program, and I am very eager to see if we can get some pioneering states who will, in fact, move to a more liberal standard of affordable, broad-scoped, and high-value coverage for children.

As far as the federal financing question is concerned, Alan makes the point -- he's totally correct; several other people have made the point, Marsha makes the point. Who knows? I mean, you know, we can look at so many different laws we're thinking about. If you look at education, it's one partnership. If you look at health care, it's another partnership. The original Medicaid statute had one. We've stuck in other federal contribution levels for administration and for medical assistance.

You know, for what it's worth, if you look at the Medicaid expansion formula, which essentially is the most modern statement we have about what Congress would like the federal-state relationship to be around sort of the new insurance market and the publicly financed insurance side of things, as opposed to the tax premium side of things, I myself would say we should settle in at the -- I want to

make sure I say this correctly -- the higher of where a state is today or 90 percent so that we come close to where the Medicaid contribution rate for the newly eligible population settles in.

I do agree that there should be some contribution on the part of states. We've come up, for better or worse -- and maybe Congress will change everything, but we've come up with a sort of split screen between that part of the subsidized market that's entirely tax financed and that part of the subsidized market that is a mix of federal-state financing. And Congress has given us a number, and if the number is good in the Medicaid statute, which is vastly bigger and a vastly bigger burden on states, then it seems to me it's a sensible number to suggest that Congress use for CHIP as well. It would actually mean a couple of states are below that threshold today, but many are above. So it sort of uses the national model to smooth things out.

Penny, yes, why don't you close us out on this section of the morning?

COMMISSIONER THOMPSON: Well, I just wanted to -- I'm not sure exactly where we stand, so I just wanted to try to circle back on some of the comments, which, you

know, I think partly we're trying to figure out kind of how to meet, as I said at the beginning, kind of in the middle. I think at the last public meeting and again here, we've had, I think, a good argument made on a variety of different sides, and, you know, last time I was certainly making the argument that MOE needed to go away, that the enhanced FMAP needed to go away, that we needed to return to regular order, that the program needed to make the argument for itself. But I do find myself reflecting on that and concerned about what, if all of that happens, we don't have the bridge that we are hoping for and we lose some of these gains that we've achieved in children's coverage.

So the idea of try to create some middle ground here always has the potential of just making everyone dissatisfied rather than sort of cleanly having an argument and a logic to their argument on either side. But I did want to come back to a couple of questions that people had about what I suggested at the kickoff of this session.

One is I, too, am concerned about putting power in the hands of the Secretary for figuring out where the flexibilities are in Chuck's and others' comments. I just

don't know where else to put it. And, you know, I think the idea of requiring rulemaking, as people were talking about this, I was making notes about requiring consultation, requiring to take into account recommendations from MACPAC. I'm not sure if we want to be doing work in this area but, you know, others who might have some data to contribute and so forth. So rulemaking may be the proper approach to that, and that may, in fact, suggest that your idea about the three-and-two, Sara, makes sense.

Gustavo, that would also, I think, help respond to your question about what are the standards that are really being employed here, and what are the specifications for that, and are we sure that that would be thought of as--you know. So the rulemaking could both be the way that you actualize what does the off ramp look like, so what are the standards that we're using that states have to provide information or that states have to meet certain standards to be able to take advantage of the off ramp, but also in terms of any national flexibilities that might be granted to give states some additional room.

And, Sara, you said -- I think this was a

misspeak on your part, but let me just clarify. Around enhanced match and the idea of taking some steps, you know, which we've all discussed are a little arbitrary, but restoring some level of state match at least across the country and having some level of reduction applied. You mentioned 90 percent or the higher of where they are. You meant 90 percent or the lower of where they are.

CHAIR ROSENBAUM: Yeah [off microphone].

COMMISSIONER THOMPSON: Okay. So that effectively--

CHAIR ROSENBAUM: I knew it was [off microphone].

[Laughter.]

COMMISSIONER THOMPSON: Just to clarify that it would be a proposal to say that the reduction would take place, and it would be either the level of the enhanced match today or 90 percent, whichever is lower.

CHAIR ROSENBAUM: Thank you.

VICE CHAIR GOLD: And just for a point of reference, most of those lower are at 88 percent.

CHAIR ROSENBAUM: Yes, very close.

CHAIR ROSENBAUM: Thank you, Penny, and thank you, everybody. This was really a tremendous discussion.

So now we have time for public comment.

COMMISSIONER DOUGLAS: Can I just on this last piece?

CHAIR ROSENBAUM: Oh, yes.

COMMISSIONER DOUGLAS: And I should have said it earlier. I guess where I was -- I was assuming it would be some equity of phasedown across all states. So I do question that, partly -- you know, none of us know the exact logic behind the 23 percent. The best rationale I've heard is that Congress was trying to create some equity on the Medicaid expansion going at 100 percent, so taking this for a lot of states up to 100 percent.

That being said, the Medicaid expansion glide path down to 90 percent, to me that's a 10 percent reduction, is that there's rationale, policy rationale of 10 percent reduction across all for the enhanced -- across all --

CHAIR ROSENBAUM: Than if you were at VA [off microphone].

COMMISSIONER DOUGLAS: So that would be, you know, what I would kind of see as more of a rational policy --

VICE CHAIR GOLD: So you wouldn't do what it is now. You'd just do a uniform 90 percent across the --

CHAIR ROSENBAUM: No.

COMMISSIONER DOUGLAS: No, 10 percent off --

CHAIR ROSENBAUM: 10 percent or 10 percentage points?

COMMISSIONER DOUGLAS: Well, it's 10 --

CHAIR ROSENBAUM: 10 points.

COMMISSIONER DOUGLAS: 10 percentage points.

COMMISSIONER THOMPSON: Can I suggest just, again, I'm trying to like -- in terms of formulating a recommendation that actually --

COMMISSIONER DOUGLAS: Maybe -- I'm sorry. I mean 10 percent reduction of 23, so it's 10 percent -- it's not points, so it's not 23 to 13. It's --

CHAIR ROSENBAUM: 10 percent off the 23 percent?

COMMISSIONER DOUGLAS: Well, total percent, yeah, like --

COMMISSIONER THOMPSON: So it's not the 23 percent. It's the match that you're reducing.

COMMISSIONER DOUGLAS: Yeah.

COMMISSIONER THOMPSON: Right.

Can I suggest, the other thing that we've maybe identified here is that any of these numbers we're kind of pulling out of the air to some extent or another. And so if our concept is what we're trying to say is that we think that enhanced funding is important, we're not sure that we have to maintain the total level of enhanced funding that came into place in 2015, that we would like to have a state contribution, could we not pick an approach but then also acknowledge in our recommendation that there are other approaches?

CHAIR ROSENBAUM: Yes.

COMMISSIONER THOMPSON: You know, that we're not, you know, sort of definitively saying this is the only way that you can do this. The concept that we're trying to do is that we want to restore a level of state contribution, we want to be prudent fiscally, we want to acknowledge that it was perhaps not Congress' intent for the total level of enhanced funding to continue over this period of time, but in light of other factors that we've been discussing, we think it's important to maintain a level above the regular CHIP match, and this is a place that you could land, bureau you could also land in a few other places, because it

really gets down to kind of almost a description of a formula.

CHAIR ROSENBAUM: I think that's a point well taken, and, of course, as we settle on finally the final wording of the recommendations, I think it goes without saying that we would be noting to lawmakers that on several of the points we are making, there are, you know, various ways to state the options, but that we've sort of settled on whatever we will settle on as our preferred option.

COMMISSIONER CARTE: I was just going to suggest that in the same way that the ACA set, you know, with the 23 percent bump that no state went beyond 100 percent, we'd have an upper bound of 95 percent so that all states at least have a 5 percent reduction.

CHAIR ROSENBAUM: So we are over time on our public comment. We have public commenters, I'm sure. And I'm sure there are people who have other work to get to. And, of course, we will be coming back to CHIP this afternoon, so we can ruminate a little over lunch and start in again.

Any public comment? Here comes a commenter.

PUBLIC COMMENT

* MS. WHITENER: Yes, sorry. Just when you thought you'd be able to get up. I'm Kelly Whitener from the Georgetown University Center for Children and Families, and thank you for this robust discussion. I'm probably a familiar face at this point. I do really enjoy listening to your conversations and the time and attention you're giving to this really critical issue.

I wanted to flag for you that today we are releasing our annual report on the rate of children's coverage, and it has reached, as you mentioned in your discussion, historic highs. So 95.2 percent of kids are covered today, and that is something to be celebrated. And it is due in large part to Medicaid and CHIP. We actually saw that Medicaid and CHIP enrollment went up over the last two years. ESI, where Alan rightly points out half of kids get their coverage, was flat over that time period. So these things are something we should pause and appreciate and recognize that they might not have been the case without the MOE. So a lot of these things are really tied closely together, and absent that MOE, we may not be able to celebrate the 95 percent of coverage that we are able to celebrate today. And I think it's important that we

continue working in that direction and getting the remaining children covered.

With respect to the MOE and the bump, I agree with many of your comments that they are tied. It would be very difficult to expect states to maintain a certain eligibility level without that additional financial support.

I also agree with some of the comments that scaling back on that bump before 2019 could potentially be very problematic for states. That is part of current law, and many states are already budgeting well into that window. So I would encourage you to think about any scaling down of that enhanced match rate to happen after the 2019 period.

One other thing I wanted to just kind of highlight for you that you may have missed is that Connecticut scaled back its parent coverage, and I think this was actually covered in one of your meetings a few months ago. And they scaled back their parent coverage from 201 to 155 percent of poverty in 2014. And other states made similar type changes, but Connecticut has been following what happened to those parents, so it really does

give an interesting look at what might happen if states were to scale back their children coverage. And what they found was that in that first year, 94 percent of the parents actually stayed in Medicaid because of TMA. We don't have TMA in CHIP, but interesting data point.

So, really, the more interesting point was to look at 2016 and what happened once TMA ended, and what they found was that half of the parents losing Medicaid coverage did not make it to the marketplace or to any other source of coverage and only 13 percent transitioned from Medicaid to the marketplace without a gap in coverage. So that gives us kind of startling insight into what might happen without the maintenance of effort or certainly without any CHIP funding at all. And so to that point, definitely support a five-year, or even longer, CHIP extension so that we can continue working in that direction of covering more and more kids.

Thank you.

CHAIR ROSENBAUM: Thank you very much.

Yes?

MS. HONBERG: Hi. I'm Lynda Honberg from Family Voices, and I think -- and I've said this before --

probably that children and youth with special health care needs are the canary in the mines. So CHIP coverage is so important, especially for the states that expanded Medicaid so that kids get EPSDT coverage.

One thing that I haven't heard today regarding maintenance of effort is as our country continues to diversify, we're hearing from our family leaders across the country how much more effort has to be made in terms of enrollment because there's just so much more time that needs to be taken with these parents in terms of explaining the various options. So I would agree that we need to maintain the five years or longer, and definitely the maintenance of effort in the matching.

Thank you.

CHAIR ROSENBAUM: Thank you very much.

MS. HONBERG: And, actually, because I won't be here this afternoon, I know you're going to be talking about the ACA. I do hope when you talk about it that you really focus on the narrow provider networks that exist in the ACA. That's a real issue that we're hearing across the country.

CHAIR ROSENBAUM: Thank you.

MR. BROADDUS: Hello. My name is Matt Broaddus. I'm from the Center on Budget and Policy Priorities, and we submitted draft comments on the MACPAC recommendations earlier, and I just want to amplify one element of those comments related to the MOE, and that is simply that there is a fiscal incentive -- and there's been some question about how states might react to eliminating MOE. There is a fiscal incentive for states to shift children from CHIP to marketplace coverage because subsidized coverage is entirely subsidized by federal dollars. And so acknowledging that that would be a potential concern that states would have to face and a step that they might take in their larger efforts to -- larger state budgeting efforts, we just want to acknowledge that that's a pressure that an eliminate of MOE would certainly place on state legislators.

Thank you.

CHAIR ROSENBAUM: Thank you. I think that is the end of the comments of for this morning. Again, we'll be back to child health this afternoon. So why don't we take a five-minute break and come back?

[Recess.]

CHAIR ROSENBAUM: All right. So we are now at preliminary analysis of policies to improve the targeting of DSH hospital payments.

PRELIMINARY ANALYSIS OF POLICIES TO IMPROVE THE TARGETING OF DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

* MR. NELB: Great. Thanks, Sara.

So I'll give you all a brief break from CHIP to dive into some preliminary analyses that we did about policies to improve the targeting of disproportionate share hospital payments, known as DSH.

So, today, I'll be walking through some analyses looking at approaches to improve the targeting of DSH payments at the provider level and DSH allotments at the state level. At the provider level, we will be looking at questions about who should receive DSH payments and what DSH funding should pay for, and at the state level, the main question we'll be thinking about is how should pending DSH allotment reductions be distributed.

This is our first foray into presenting some preliminary policy options for you all with the limited data that we have available, and so I'll look forward to

your feedback on whether there's interest in developing any of these particular targeting policies into formal recommendations and what sorts of information would help you all to weigh some of these different policy options.

As you will recall, MACPAC is required to report annually on Medicaid DSH payments, and in MACPAC's first DSH report, which was released in February of this year, the Commission found little meaningful relationship between current DSH allotments and measures meant to identify those hospitals most in need.

As a result, the Commission concluded that DSH payments should be better targeted to both the states and hospitals that serve a disproportionate share of Medicaid and low-income patients and disproportionate levels of uncompensated care.

The Commission's next DSH report is due in March of 2017, and it provides an opportunity for the Commission to further explore approaches to improve the targeting of DSH payments.

So, with that introduction, let me begin by presenting some analyses of approaches to improve the targeting of DSH payments at the provider level.

As you will recall, under current law, states can make DSH payments to any hospital that has a Medicaid inpatient utilization rate of at least 1 percent, which is a standard that virtually all hospitals need.

In addition, states are required to make DSH payments to hospitals meeting the deemed DSH standards listed here: a Medicaid inpatient utilization rate one standard deviation above the average in the state, or a low-income utilization rate above 25 percent. You will recall that the low-income utilization rate looks at both the Medicaid and the uninsured.

The amount of funding that DSH hospitals receive is largely left up to the states; however, DSH payments to a particular hospital cannot exceed the hospital's uncompensated care costs for both Medicaid and uninsured patients.

This figure shows the share of hospitals receiving DSH payments in 2012, and as you can see, there's wide variation by state. Nine states made DSH payments to less than 20 percent of the hospitals in their state, while eight states made DSH payments to more than 80 percent of hospitals. Nationally, about half of hospitals received

DSH payments.

So, as we move forward and you consider approaches to improve the targeting of DSH payments, I just want to emphasize that the states that currently distribute DSH funding most broadly would be most affected by policies to target DSH payments to a narrow subset of providers. And there's more information about current state DSH targeting policies in your materials in Appendix C.

Today, we are going to look at three provider targeting approaches based on some of your feedback from earlier conversations.

First, we're going to look at raising the minimum federal eligibility criteria for DSH to a higher threshold than that 1 percent utilization.

Second, we're going to look at expanding the DSH definition of uncompensated care to include all services that hospitals provide, including physician and clinic services.

Third, we're going to look at narrowing the DSH definition of uncompensated care by excluding Medicaid shortfall, which states can address outside of DSH by including their base payment rates.

To look at that first approach about the effects of raising the minimum eligibility standards, this chart shows the characteristics of DSH hospitals meeting some various utilization standards.

The first to consider is the deemed DSH standard, which is in the second column there to the right. You can see that in 2012, deemed DSH hospitals received the majority of DSH payments, about $10.6 billion out of a $16.2 billion in payments made. However, deemed DSH hospitals are only about a quarter of all DSH hospitals -- 733 out of the 2,663 that received payments.

Another possible standard that we present here is what we call above-average utilization, and using a similar formula as the deemed DSH standard, we defined above-average utilization as either a Medicaid utilization rate above the average in the state or a low-income utilization rate above 10 percent. That's represented at the middle column there.

If you raise the minimum eligibility threshold to above-average utilization, then these hospitals on the left with below average utilization, that would be affected. You can see that only 781 hospitals, or about a quarter of

DSH hospitals, had below-average utilization. So fewer hospitals would be sort of disrupted by this change, but at the same time, only $1.7 billion in DSH payments were made to these hospitals with below-average utilization. So there would be less DSH funding that could be reallocated to hospitals that serve a higher share of Medicaid and low-income patients.

More information about the characteristics of hospitals in these different buckets, urban rural status and other information is in your materials.

All right. Second, we are going to look at expanding the DSH definition of uncompensated care. Currently, DSH payments only cover uncompensated care for inpatient and outpatient services based on Medicaid definitions, and so physician or clinic services that hospitals provide are not included.

To get a sense of the magnitude of these costs that aren't included, we looked at Medicaid claims data from 2012 and found that these other services provided by hospitals accounted for about 23 percent of Medicaid fee-for-service payments to hospitals in 2012, and most of these, again, were the physician and clinic services in the

outpatient settings.

So, as a result, we estimate that if we adopted an expanded definition of uncompensated care, it would increase the maximum amount of DSH payments that hospitals could receive by about 30 percent.

I want to emphasize that this analysis is preliminary, based on aggregate data for all hospitals, and we're currently working on gathering information about how particular DSH hospitals would be affected.

The final provider-level targeting approach we're going to look at is narrowing the DSH definition of uncompensated care to exclude Medicaid shortfall. We are going to look at two approaches to eliminating shortfall: first, excluding all Medicaid shortfall; and second, a narrower policy that would only exclude Medicaid shortfall for patients who are dually eligible for Medicaid and Medicare.

We'll highlight the dual eligibles in particular because Medicare is the primary payer for hospital services for these patients, and it also makes separate DSH payments that could be considered potentially duplicative.

Under both approaches, if you narrow the

definition of uncompensated care, then some hospitals would receive lower DSH payments if their current level of DSH funding is higher than that more narrow definition.

So, to get a sense of it, this chart presents information on the share of hospitals, with DSH payments exceeding that narrower definition of uncompensated care in 2012.

We found that about a quarter of hospitals would be affected if all Medicaid shortfall were excluded, and that about 10 percent of hospitals would be affected if only shortfall for the dual eligibles were excluded.

Deemed DSH hospitals, presented in the right column, are slightly more likely to be affected than other types of DSH hospitals.

I do want to caution that this chart is based on DSH audit data from 2012, and so the number of hospitals that would be affected would likely be different today after the implementation of the Affordable Care Act's coverage expansions.

In addition, I want to point out that we can't model how states might change their regular Medicaid payment rates or other non-DSH supplemental payments in

response to this change, so this is just looking at the effects on DSH payments in particular.

After reviewing those provider-level targeting approaches, I am now going to turn to looking at some approaches to improve the targeting of state DSH allotments.

As a reminder, federal DSH allotments are scheduled to be reduced by about $2 billion in fiscal year 2018, and the amount of the reductions increases each year up to about $8 billion in 2025.

The statute requires CMS to develop a methodology to distribute DSH allotment reductions among states, and in 2014, CMS initially proposed a method to distribute the allotments based on the three factors listed here. CMS is expected to update this model in January of next year, and the Commission will have an opportunity to comment on any proposed rule.

Today, we're going to look at three alternatives to CMS's initially proposed DSH allotment reduction formula. First, we're going to look at what happens if you apply DSH allotment reductions to unspent DSH funding first. Historically, there's about $1.3 billion in federal

DSH funding that is unspent each year, and so if you apply the reductions to the unspent funding first, it could help minimize the effect of DSH cuts on hospitals that rely on DSH funding today.

Second, we are going to look at including both Medicaid and uninsured patients in the DSH allotment reduction formula rather than just the number of uninsured individuals in a state.

And, finally, we're going to look at the effect of revising the uncompensated care factor that's used to distribute the reductions.

So this first table shows federal DSH allotment reductions, including and excluding unspent DSH allotments. For comparison purposes, we also showed the DSH allotment reductions that were initially scheduled to take effect in 2014 under the ACA but have since been delayed.

In 2018, you can see that if you exclude unspent DSH allotments, the size of the reduction would be reduced from $2 billion to $.7 billion, allowing for a more gradual phase-in of DSH cuts. However, either way, the amount of the reductions is less than the $5 billion that was initially scheduled to take effect in 2018 under the ACA.

I do want to note that some states would be more affected by this policy than others. In 2013, for example, four states accounted for about half of the unspent DSH funds -- Massachusetts, Louisiana, New Hampshire, and Pennsylvania -- and so these states would be most affected. More information about the particular situations in those states is in your materials.

The second state approach we looked at is including Medicaid and uninsured patients in the allotment formula. As I mentioned, as you know, DSH offsets uncompensated care for both Medicaid and uninsured patients, but the formula initially proposed by CMS only accounts for the number of uninsured in the state. So to get a sense of how the different measures compare, whether you just include the uninsured or include Medicaid and uninsured, we examined the relationship between some of these different state population factors and levels of uncompensated care for deemed DSH hospitals in 2012.

We found, very unsurprisingly, that the number of uninsured in the state is better correlated with hospital uncompensated care for the uninsured, and that the number of Medicaid and uninsured patients is better correlated to

hospital uncompensated care for both Medicaid and uninsured patients, which, as I mentioned before, is the current DSH definition.

As we look at the potential effects of this policy across states, we find that including both Medicaid and uninsured patients minimizes the differential effect of DSH allotment reductions on states that expanded Medicaid, compared to the formula initially proposed by CMS, which bases reductions on the number of uninsured and results in larger reductions for states that have expanded Medicaid through the ACA.

Lastly, the third approach that we're going to look at is revising the uncompensated care factor in the DSH allotment reduction formula, which is used to identify hospitals that have high levels of uncompensated care. This is a bit technical but has important implications for targeting across states.

So the factor initially proposed by CMS compared hospital uncompensated care to the Medicaid and uninsured costs only, and the reason they did this was because it's information that's readily available on the DSH audits. However, hospital associations and other commenters on

CMS's proposed rule suggested that hospitals' uncompensated care costs be compared to its total costs of care for all patients to be more reflective of the effect of uncompensated care on overall hospital finances.

These costs aren't available on DSH audits, but they are available on Medicare cost reports for all hospitals in the state rather than just DSH hospitals. One drawback of using cost reports is that it may not be as reliable as DSH audits.

So to analyze this policy, we looked at which hospitals would have met these different uncompensated care thresholds in 2012, and we found that if you revise this factor, it would better encourage states to target DSH funding to deemed DSH hospitals.

And this final chart just shows, again, the share of hospitals meeting various uncompensated care thresholds. You can see that the initially proposed uncompensated care factor -- you can see that the deemed DSH hospitals, which are on the right, are less likely to meet the initially proposed uncompensated care factors, but deemed DSH hospitals are more likely to meet the revised uncompensated care factor that we modeled here.

So that concludes my presentation for today. As I mentioned before, this is a very preliminary analysis in our first foray into modeling some of these policy options for you, and so I look forward to your feedback on whether there's interest in developing any of these particular policies further.

In addition, although the data we have are limited, I do welcome your feedback on whether there's other information or better ways of presenting the data that would help you weigh some of these particular policy options.

Thanks.

CHAIR ROSENBAUM: Thanks, Rob.

So let me open it up for discussion and see if we have anybody eager to kick it off before I pick an eager person to kick it off.

Oh, Stacey. Great.

COMMISSIONER LAMPKIN: I will start off. I have some questions and comments about this.

So the first one is around the provider-level targeting ideas that you presented, and in particular, the idea to focus that on uninsured uncompensated care only

rather than Medicaid shortfall. That's a really intriguing concept to me, and let me explain a little bit why.

I think from a transparency and simplicity perspective, putting those Medicaid costs in Medicaid, where you can see how much things are costing and you can track that rather than hiding some aspect of it in DSH, it just seems really appealing to me.

But it seems like making that change at the provider targeting level has implications or there's interaction there with some of the state-level targeting, I think.

And, Rob, I need you to help me understand if I'm thinking about this right. If we were to recommend and Congress were to adopt that provider targeting aspect to take the shortfall out, would that not imply that there would be unspent funds, perhaps, in some states that expanded Medicaid, where they have fewer numbers or less uncompensated care to spread the dollar -- I'm not asking the question well. I'm hoping you're getting something from it.

CHAIR ROSENBAUM: No, I think you're asking what, in fact, a number of us around the room who are very

curious about the same thing.

MR. NELB: Yes. So, if you just alone remove Medicaid shortfall from the formula, some hospitals would have lower DSH payments today because the total -- the hospital-specific cap for their DSH payments would go down. If you combined it with some of the other policies, including some of the other services that they provide, it may end up washing out. But, yes, if you just make that change by itself, it could potentially lower some funds that some hospitals could receive.

COMMISSIONER LAMPKIN: So do we have the ability, with the data we have, to model some of the interaction effects of this so that modeling that change along with increasing to the outpatient services or in isolation to understand the implications?

MR. NELB: Yes, we could merge those two options together and show you what that would look like.

COMMISSIONER LAMPKIN: Okay. That would be of interest to me, and then also the state targeting aspect of including not just uninsured population but the Medicaid as well, which would then be out of sync with the way that the DSH limits were defined. And so how all that fits together

I think would be interesting to see.

And I have just one other quick question. I think the reading materials said that some of the clinic services were FQHC related. Does that cause any complexity around prospective payment systems and the nuances that go there? And how much do we worry about that?

MR. NELB: Yes, so it does create some interactions between the two. That was part of CMS' rationale for not including the clinical services because FQHCs receive sort of an enhanced rate already for those services. So there's the services that they provide to the uninsured, which, you know, they're not getting directly paid for by Medicaid. So the PPS rate would be considered to help offset some of those costs.

CHAIR ROSENBAUM: Can I ask just one follow-on? I think it's related. I'm sort of struggling in my head with whether it's related, and then Penny's hand is up.

So if you look at hospitals that are tax-exempt organizations, right now the chief sources of allocation are financial assistance at cost and Medicaid shortfall. So if we, of course, alter the formula -- if we were to recommend an altering of the formula on the Medicaid DSH

allocation method, we would also -- we would likewise expect to maybe see differences in how hospitals allocate for tax purposes. I assume that the Medicaid shortfall payment element of DSH does not make up all of the Medicaid shortfall. It offsets some of the Medicaid shortfall. So if you're, you know, a hospital, if you're Holy Cross Hospital today, some of your shortfall is showing up on your tax-reporting side, and some is showing up on your DSH formula side. And I think it's just interesting to note that if we push all shortfall essentially out of Medicaid, in other words, if we say, no, don't use DSH for that, use DSH for uninsured, I would expect to see that the Medicaid shortfall side on charitable reporting would go up -- where else are you going to put it then? -- and that the effect might be on the financial assistance side. And I just flag it because at some point I think these things -- I think we ought to be -- even though we're not making tax policy, there may be indirectly some financial assistance implications on the uninsured but Medicaid-ineligible side of the ledger for some hospitals that we might want to at least identify.

COMMISSIONER THOMPSON: All right. Well, I think

I have a pretty targeted question. I liked, Stacey, where you were going because I was having the same question about kind of thinking about policy coherence, how all the pieces fit together in terms of what we're trying to recognize and encourage. And I think kind of like almost at a story level, like if your story was that you wanted to recognize and incentivize this, here are the combinations; if you wanted to do something else, that might be a helpful way to think about organizing it.

I had a question about cost report data, and so I appreciate your statement that these costs are available in Medicare cost reports for all hospitals, but the data may not be as reliable. I'm wondering if there's any quantification. Like is it so unreliable that we should -- you know, how should we think about some of that data?

MR. NELB: Sure. So in Medicare, actually, they've been looking at using cost report data, uncompensated care for distributing Medicare DSH payments, and so there have been various proposed rules and sort of comments on that which have given some insights and reliability.

From the perspective of not having them as much,

it does seem like when you're calculating averages or general stuff, like we would for this revised uncompensated care factor, it seems to be, you know, the outliers sort of balance each other out. When you use it to distribute payments to particular hospitals, there are just these couple outliers from the data that sort of skew it. And so that's something to consider.

But, you know, MedPAC has made the point that if the cost reports start being used for distributing some of these DSH payments, that maybe the reliability of the data will improve. So sort of a chicken-or-egg thing, but another point--

COMMISSIONER THOMPSON: Well, or the opposite.

MR. NELB: Yeah.

COMMISSIONER THOMPSON: I mean, that's possible.

I guess I'm just trying to understand, is it an issue -- so what I take from your comment is it's probably good enough for estimating overall effects. But if you're also using it to operationalize the policy, that's when you're going to come into some trouble. Is that a way to think about what you just said?

MR. NELB: Yeah, and it depends which policy

you're operationalizing. So I think the one we had proposed, where you're just using it to figure out what the average level of uncompensated care is in the state, there may not be as many issues with it. If you then use it to also figure out what the level of uncompensated care is for a particular hospital, then you might have more issues.

COMMISSIONER WEIL: This is always ridiculously complicated, and I'm trying to start from -- it's very different from CHIP, obviously, but it has some of the same issues. You know, DSH -- I take as a starting point that how states have chosen to place the expectation and then pay for care provided to those who don't have insurance is highly variable, and I don't think we have a mandate to change that. So a lot of the state-by-state variation in how they approach DSH reflects that.

And then I think about the tradeoff between just using regular payment methods as opposed to DSH, and although you can have a lot of fun with your regular payment methods, at least -- I think for states there is the -- DSH has this whole targeting element that you can really say this is where -- you know, this is who's bearing the burden, this is who we want to support. So they're

complements and need to be thought of together.

So where I find myself, as you mention these different ideas, is I find myself in -- that we're in this very funny spot with respect to payment policy, so forgive me for the digression. But it used to be, I think, that DSH was heavily criticized, you know, as a supplemental payment, as not linked to individual provision of services; that, after all, that's what makes it possible to play the games.

We are now in this whole world where everyone's really excited about payments that aren't linked to individual services because, you know, fee-for-service is bad and it drives volume, and what we want to reward is outcomes and quality and not have incentives for volume. And so all of a sudden this thing that we demonized as unaccountable is now like the solution to everything wrong with health care, which is to decouple payment from individual transactions.

And so I think we're -- so in some sense, DSH has the burden of this history of being, you know, a game and all of that, but is now part of DSRIPs and other methods that states and other payers, with whatever techniques they

have, are using to try to drive delivery system improvement. I think it would be very odd for us to treat DSH now as the old problem when people are trying to use it to address a new -- as a new tool to address a problem. So that makes me very hesitant just at a conceptual level to start putting a bunch of changes or strictures on it when how the dollars are being used is being changed so dramatically.

Sorry for the length of that, but I just was really struck as I was looking at all these option, saying, why am I having trouble making sense?

So I come back to two things that I think are important that don't quite line up, forgive me, with what you raised here but hopefully are slightly helpful.

One is that the level of the facility-specific cap becomes really important because that does tie to the old bad stories about whether, you know, this is being used -- the funds are being used appropriately. And so I think things that expand what we count as viable things to spend DSH funds on, I think we run the risk of expanding the narrative of the problem of these being unaccountable.

But the other -- and I know MACPAC has a long

history on this, and we're not the only ones -- is that the lack of knowledge -- that the need for transparency and the information about this spending becomes now, I think, more important because we're using it for different purposes. And I would much rather put more of the emphasis at this stage on trying to really understand -- and we're doing this. This is not criticism. I think in terms of where our energy goes, more to understand how it's being used is more important that trying to tweak where it goes when its uses are being changed so dramatically.

CHAIR ROSENBAUM: Thank you.

COMMISSIONER RETCHIN: Well, first of all, I just want to thank Rob for his work in the middle of everything else that was going on in his life. I guess you did this in Japan, but it translates nice.

[Laughter.]

COMMISSIONER RETCHIN: And, second, I promise my fellow Commissioners not to tie this back to the compelling scene in "Blazing Saddles," waiting on --

[Laughter.]

CHAIR ROSENBAUM: We need another movie [off microphone].

COMMISSIONER RETCHIN: Another Mel Brooks, I'm sure. I'll try "Frankenstein."

Just to point out one thing on the Medicaid shortfall, that if we don't either include those costs or migrate to include other costs that we want to incentivized -- and I keep getting back to the network, changing DSH to DSS, that is, disproportionate share system payments rather than hospital payments, that if we don't do that, then we're really punishing those providers that, pre-expansion, were getting around, let's say on average, 92 percent of costs. In the expansion states, they've now got Medicaid, but largely at about 70 percent of costs. I'm guessing. I'm just choosing that. And so the shortfall becomes meaningful.

Also, just to say that I do think in front of us as a Commercial -- I've said this several times -- that to abdicate from some responsibility coming forward now with cuts being a blunt instrument at a time when there are -- the variation, the heterogeneity among states is just extraordinary, and there are some real peanut butter approaches out there, I think that's a mistake.

So I look at, at least trying to target some

element first on Slide 8, and I don't know, Rob, if that's where you were going, but looking at those providers that really are off the grid, is that the 781? Are you identifying -- would you say that those are hospitals that, by and large, we just really can't -- that they're getting a small piece of the DSH, but still folding money, the $1.7 billion?

MR. NELB: Sure. So it's up to, you know, the Commission to figure out what the right threshold is, but these are the ones that serve the lowest share of Medicaid and low-income patients, tend to have higher operating margins, even before DSH payments.

COMMISSIONER RETCHIN: Yes.

MR. NELB: And, you know, so that's there. There may be some particular types of hospitals, and in your materials, we go into more about, you know, whether IMDs or some hospitals that might have lower utilization for other reasons, you know, might want to have a different standard or rural hospitals or something. But this was a first cut at trying to get a sense if some is better at the lower tail of the distribution.

COMMISSIONER RETCHIN: So I guess where I come in

is we have an immediate issue, a cut of $2 billion right ahead of us that I still think we ought to weigh in on, but then a longer obligation that will take us to the full, I guess, $6 billion in cuts by 2022, that to me offer an opportunity for us to redirect DSH, including -- so that we are able to target those providers that are incurring these other costs in a system approach, hiring -- or developing particularly in primary care and maybe even behavioral health.

CHAIR ROSENBAUM: Great. Thank you.

COMMISSIONER MILLIGAN: So I make my notes before I offer these comments, and then by the time it gets to me, it's like I've got 65 more things that I shouldn't say. This is a good conversation. I want to make a few points.

The first is I'm supportive of targeting. I'm not sure when we're going to have enough information to meaningfully weigh in on that, but I do think that DSH is intended to be used and should be used for those health care institutions that disproportionately serve Medicaid and the uninsured. And I think that we should align ourselves to that targeting philosophy.

A few other kind of random thoughts that have

come along. I do agree -- Alan, it was interesting the way you framed it about, you know, we're moving in the direction of population health and payment for value, not payment for units and transactions. But I do think that transactions or admissions or ED visits or whatever is still probably the best proxy for the payer mix at a given facility. And I still think that we can work on a targeting approach that's based on a patient mix that uses those kinds of proxies and still to me a deemed hospital is still worthy of more support. And I think that even if they're doing a great job of avoiding admissions, readmissions, ED visits and the like, there are going to be those things that I think are going to be a good proxy. And I do think that DSH can help support that.

I want to make this comment and then just sort of set it aside. DSH isn't the only supplemental payment, obviously, to hospitals, and both of the states I'm most familiar with, New Mexico and Maryland, use other -- you know, UPL and intergovernmental transfer strategies to help other hospitals. And so I just want to say -- and I know, Rob, that you did a good job in your materials about this -- that when we look at who's getting the DSH funding, it is

a limited view because a lot of other hospitals are getting a lot of supplemental funding.

Two comments, I guess, and I'll stop.

The first is I do have some trepidation to Sheldon's comment about looking at a system-wide level, and I want to share my trepidation. I think that there is value in the view that supporting the system as an enterprise in primary care makes sense with DHS. I support that principle. Where I get concerned is I think as more and more health care systems have moved to employment models with physicians and moved toward hiring, you know, private providers who used to be in private practice, states are seeing an upward pressure on spending because a lot of those visits not only then have the professional component, they have a facility component attached to them with whatever outpatient facility the doctor is now -- or, you know, the health care professional is now supported through.

And so I worry a little bit about inadvertently creating incentives that would enable more of an employment model that would drive up the unit cost part of a Medicaid person going to be seen at a hospital-affiliated primary

care clinic, where it's not just the professional fee anymore but there's a facility-based component as well.

And I guess the other comment I'll make in closing is one of the reasons I do support targeting is that, as with CHIP, a lot of the allocation states have gotten over the years from DHS are really based on where they started. And I think that there is some fundamental inequities in DSH allocations that have nothing to do with where the need is and a lot to do with when the snapshot was taken of their DSH spending based on previous federal maximization gaming kinds of activities.

So I'll leave it there.

CHAIR ROSENBAUM: Thank you. Toby.

COMMISSIONER DOUGLAS: So I want to start with just reminding everyone the reports that we did or went over last time, it made me see that Medicaid payments to hospitals are now approaching, in many cases, up to Medicare levels. Obviously, that's not even everywhere, but that gets to kind of Chuck's point too. This is one piece, and so that's where I start to definitely align with what Sheldon is saying of thinking through the targeting to be more broad around the system and driving not just

inpatient, but looking at primary care.

I question the idea that the payments right now are value-based because it's cost-based reimbursement. The more you spend in an inpatient, the more you get. Now, there's a cap in DSH, but it's cost-based on that respect.

If we want to incentivize from a value base, it's incentivizing delivery system changes to a primary care, and so I really think that we should think through a broader definition of where the dollars can be spent. So I'll leave it at that.

CHAIR ROSENBAUM: Thank you.

Andy.

COMMISSIONER COHEN: Great work and congratulations.

Just a couple of points. So, first of all, I want to go to the Slide 8 also, like Sheldon, and I just have had this burning question. We have various categories of below-average utilization, above-average utilization, not deemed, and deemed, and in each case, we have tied a relative standard with an absolute standard. So we say Medicaid utilization is below average, where low-income utilization is less than 10 percent, meaning above 10

percent. You would be in this model in an eligible-for-DSH category. I wanted to go into sort of how you design those.

In some states, Medicaid is a much bigger payer than in other states. Obviously, in New York, it's a very, very big payer, and if you have 10 percent Medicaid, that is so far less than the general population. It's disproportionate in the other way.

I do want to make reference to the words "disproportionate share hospital." It's supposed to be for hospitals. Maybe we should think about that, but, you know, hospitals that provide an unusual amount of care to -- or a disproportionate amount of care to low-income and Medicaid patients.

So I kind of want to come back to this, tying the absolute standard with the relative standard, and think a little bit about whether that makes sense, considering the variation across states.

MR. NELB: Sure. Part of the reason, I think, is actually to facilitate this conversation: Do you want an absolute standard or a relative standard?

If you remember last month, we do find that

although the Medicaid utilization rates vary a lot by state, depending on whether they've expanded or not, low-income utilization rates, which looks at Medicaid and uninsured, are sort of more similar across states. Perhaps a national standard for that would work.

There's some technical things that calculating the low-income utilization rate is a little more complicated. We have information about the distribution of low-income utilization rates in your materials, but we are able to use the DSH audit data, which is sort of more certain about what the actual rate is when we're doing it this way. But both approaches are possible.

COMMISSIONER COHEN: Okay. So I guess, with that, I would just say, personally, I'm sort of more oriented toward a more relative standard --

MR. NELB: Yes.

COMMISSIONER COHEN: -- that takes into account the very word "disproportionate" and sort of looking state by state, so that was one thing.

The second point goes to Alan's original point and what we've all sort of circled around here, which is that the extent to which DSH like so many other things in

Medicaid is really kind of a dinosaur, it is, nonetheless, a very essential dinosaur off of which we have hung many wonderful things. But it is not designed with sort of the health care models of the future, and so I do think we have to think very carefully about a short-term and long-term strategy with respect to DSH. We have an immediate issue, which is that the looming, very substantial changes in the amount of DSH provided to some very vulnerable hospitals and health care providers, but in the big picture, like the whole model to me, incentivizes not the right things at all. And I hate to really sort of double down on that with a design that is really based on today and built for tomorrow, so I think we should think very tactically about sort of the immediate issues, and then another body of work should be a much longer-term body of work around really rethinking DSH and what it could and should be to incentivize the right things in health and things like crazy, things like that, so that's that point.

Then thinking tactically, I do to back to some of the issues in the targeting discussion and thinking about states who are not presently using their DSH, and I just wanted to know. I think one of the things you said, that

that would have a substantial impact on some states, the states that are not fully using their DSH. And I just want to remind us in terms of framing. States aren't really benefitted by DSH. It's providers who are benefitted by DSH, and I think when we're talking on the cliff of a big, big change with respect to the safety net, taking away the potential for a state to do something with a dinosaur program sometime in the future versus taking real dollars away from safety net providers, to me that comes to a relatively easy choice. So I would say I would be fairly inclined to think hard about a recommendation or orientation around taking those unused dollars off the table first.

CHAIR ROSENBAUM: Okay. Let me just remind everybody: We are way over time. I have Marsha and Sheldon on the list, and then we still have a public comment period. If we want to have anything to eat before we start at one, I am going to close us down. If we have any lingering two seconds worth of thoughts, we can always pick it up.

Go.

VICE CHAIR GOLD: Okay. I have, I guess, three

comments or questions.

The first deals with the allocation across states. I think your analysis in here is very useful and seems like it's quite relevant to the immediate decisions that CMS has to do. If you could remind us on the schedule -- and I would argue that to the extent we have an ability to weigh in, either officially or unofficially or talking to CMS, it would be potentially useful to know what the timeline is so that we can do that.

MR. NELB: Sure. So the $2 billion in DSH allotment reductions is scheduled to begin in fiscal year 2018, which begins in October of 2017. Last I checked, CMS was planning to issue a proposed rule in January, and so it's unclear whether that will come before or after we finalize the work on the report that's due in March, but somewhere in that time frame.

VICE CHAIR GOLD: So does that suggest we might want to focus on that a little in the December meeting? So, even if it's not final, the signals are out there?

CHAIR ROSENBAUM: That makes great sense.

VICE CHAIR GOLD: Okay. The other two comments are shorter. One is that I guess I'm a little concerned.

I don't quite know how expanding the definition of DSH to health system works. I do think it's appropriate, given the change in the health system that health system be there, but I would hate to do anything that moves more money into the DSH bucket if it had that effect versus change how you allocated what's already in DSH, because DSH has had all these problems. And I think we do run into some problems of double payment if some of those providers are already paid to do it. So more analysis of sort of what it would mean to expand it, is that just changing allocation or is it changing the pot would be useful?

And I also wanted to sort of align myself with the concern, given the goals of DSH, as at least it was stated, that some of that variation across the states and the fact that so many hospitals get DSH in some places concerns me, and so I think that the information you have on Table 8 is useful. And maybe sorting out what we know now versus what we don't and what we might be able to make a recommendation on versus what we don't would be useful.

CHAIR ROSENBAUM: Thank you, Marsha.

Sheldon, you've got the last word.

COMMISSIONER RETCHIN: That's what I always

wanted.

[Laughter.]

CHAIR ROSENBAUM: Another movie.

COMMISSIONER RETCHIN: I see everybody is very hungry.

But I just wanted to clarify -- and I think Chuck raises a very good point -- that, today, there are some hospitals that in their employment arrangements, of course, they're able to drop two bills, a UB-92 or whatever it is and then a HCFA-1500. I at least wasn't proposing that we expand -- and to your point, Marsha -- expand this cost reimbursement, so that instead -- and I call your attention again to Table 4. The DSH reductions are prodigious. They're large reductions coming up. All I'm suggesting is that as we bring this down that we take a system approach.

So the system approach could be nothing more than to say -- so, if you look at hospitals and physicians, a hospital's utilization rate on Medicaid could be 15 or 20 percent. If you then look at the physician, employed physicians who work at the hospital and their utilization rate is 5 percent, Houston, you have a problem. What you've done then is you've squeezed out a portal of entry,

a very important one, by the way, and all they're doing is they're funding their bad debt through their emergency room emissions that were previously admitted through EMTALA.

So what I'm suggesting is, as you come down, just allocate the reductions so that it goes away from those who were taking a system approach. It's in keeping with Alan saying, not to reimburse the cost, but rather to make those that are more targeted.

CHAIR ROSENBAUM: Thank you so much. Thank you, Rob.

And we have an open mic again for comments on this presentation.

PUBLIC COMMENT

* MS. GONTSCHAROW: Hi. Good afternoon, everyone. I promise to be brief because I know it's lunchtime. My name is Zina Gontscharow. I'm from America's Essential Hospitals, and I'd like to thank the Commission on its continued focus on the issue of Medicaid DSH, and we are really looking forward to the March report, to say the least.

Our overall goal, as always, is to ensure that essential hospitals have the financial resources they need

to keep their doors open and provide services to all patients, particularly low-income and other vulnerable people. This is consistent with Congress' stated intent in the DSH statute. Therefore, we support Medicaid DSH payments that are targeted to those hospitals that are providing this case to the Medicaid and uninsured, and the disproportionate burden that these hospitals face must be recognized and incorporated into any DSH reduction methodology.

Thank you very much.

MS. LOVEJOY: Hi. I'm Shannon Lovejoy with the Children's Hospital Association. Thank you very much for the opportunity to provide comments.

I just wanted to highlight that DSH payments are critical to children's hospitals, and as mentioned in the last discussion, we've done a really good job in this country insuring children, so there aren't a lot of uninsured children. There wasn't even pre, before the ACA, and so children's hospitals rely on DSH payments to target the Medicaid shortfall. Over half of their patients are on Medicaid. They do not see a lot of uninsured patients because we've done a really good job of covering kids.

So we urge you, as you are looking at ways to target payments, that you're still including the Medicaid shortfall in that component as well as looking at hospitals that treat uninsured patients.

Thank you.

CHAIR ROSENBAUM: Thank you very much.

With that, we are adjourned until one o'clock.

[Whereupon, at 12:20 p.m., the meeting was recessed, to reconvene at 1:00 p.m., this same day.]

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AFTERNOON SESSION

[1:07 p.m.]

CHAIR ROSENBAUM: So here we go, back with our one o'clock session on Medicaid fraud control units. Sorry for the delay. Take it away.

PROPOSED REGULATION: REVISIONS TO STATE MEDICAID FRAUD CONTROL UNIT RULE

* MS. BUDERI: Thank you.

Today, we're going to discuss the proposed rule on Medicaid fraud control units, referred to as MFCUs, which was issued by CMS in September.

I am going to give you some brief background information on MFCUs, go over some of the key provisions in the proposed rule, highlighting specific areas where CMS is inviting comment, and then I am going to turn it over to Jess to discuss the proposed rule's relationship to ongoing MACPAC work.

The proposed rule is the first wholesale revision to the rules governing MFCUs since they were originally promulgated in 1978. Because the changes are primarily technical in nature and intended to codify changes to policies and procedures that have since developed, we do

not anticipate the Commission will want to submit formal comments on the provisions of the proposed rule. However, it does have some implications for ongoing MACPAC work.

Just as a reminder, the Commission is not required to comment on proposed rules, but if it chooses to, staff will prepare a letter that reflects the discussion at this meeting, due to CMS on November 21st.

States began establishing MFCUs after Congress enacted the Medicare-Medicaid Anti-Fraud and Abuse Amendments in 1977, and subsequent amendments made this a state plan requirement.

The Office of the Inspector General for the U.S. Department of Health and Human Services is responsible for the funding, oversight, and recertification of state MFCUs.

MFCUs are single identifiable entities of state government charged with investigating and prosecuting Medicaid provider fraud and patient abuse or neglect in health boarding and care facilities. They have a 75 percent federal matching rate, and these federal funds are administered separately from other state Medicaid funds to ensure that MFCU activities are solely devoted to MFCU functions.

MFCUs are also required to operate separately from the state Medicaid agency and are housed within the state Attorney General's office in 43 states and the District of Columbia, which means they have statewide prosecutorial authority. North Dakota is the only state without a MFCU because it has received a waiver from the federal government, and the U.S. Territories do not have MFCUs.

So, as I mentioned, the proposed rule is primarily making technical adjustments or codifying policy and practice changes, and you can find a detailed summary of the provisions in the appendix of your meeting materials. Some of these changes include changes to definitions of key terms, including altering the definition of a provider to include providers -- to clarify that those who are not furnishing items or services under Medicaid can be the subject of a MFCU investigation or prosecution, such as ordering and referring physicians.

CMS is also proposing to expand the definition of patient abuse to include misappropriation of patient funds. MFCUs would be required to investigate credible allegations of such cases, though CMS has chosen not to specify whether

the patient funds would need to be held at the facility or whether the perpetrator would have to be an employee of the facility in order to trigger that requirement. And CMS is inviting comment on whether it should specify these elements in the final rule.

The proposed rule would also implement several requirements affecting MFCU staffing, organization, and capabilities. CMS is proposing to clarify that in order to be considered a single identifiable entity, each MFCU will need to be a single organization with a single unit director, operate under its own budget separate from its parent division or agency, and locate its offices in contiguous spaces. CMS is inviting comment on whether these requirements are appropriate.

Additionally, MFCUs that are not located in a state Attorney General's office or another office with statewide prosecutorial authority, which, as I mentioned, is only a handful, would be required to establish formal written procedures for how they will refer suspected cases of patient abuse and neglect to other entities with statewide prosecutorial authority. Currently, such procedures are required only for criminal fraud cases.

There are some small changes to requirements around MFCU employee, staffing, and contracting arrangements. For example, the proposed rule would allow MFCU professional staff working part-time to conduct core MFCU audit investigation and prosecution functions but would not allow contractors to do the same.

Finally, MFCUs would be required to provide adequate safeguards for sensitive electronically stored information, and I just want to note here that CMS has said most MFCUs are already in compliance with these requirements.

The proposed rule also includes some requirements around communication and collaboration with the state Medicaid agency at federal entities, and I am going to turn it over to Jessica to discuss those and how they tie in with some of what we have been finding in ongoing work on Medicaid program integrity.

* MS. MORRIS: Thank you, Kacey.

Aspects of this proposed rule address communication and collaboration across federal and state entities. The rule requires collaboration on shared cases and establishes, for example, circumstances where the MFCU

would have to seek HHS permission to investigate, such as cases that involve both Medicare and Medicaid.

It also clarifies the data required for recertification purposes of the MFCU.

The proposed rule also addresses communication and collaboration with the state. It codifies written policies and procedures with the state, such as in a memorandum of understanding, or an MOU, laying out the scope of a state and MFCU's responsibilities and procedures for communication. It also describes the circumstances under which the MFCU would have to submit information to the state agency, such as when a provider is under investigation or if a referred matter warrants continued suspension of payment.

CMS believes, again, states are generally already communicating and collaborating with HHS OIG and the state, so these are mainly just clarifications and tweaks to the requirement.

And while the MFCU has to notify the state of an ongoing investigation, the proposed rule does not address a requirement to notify a managed care organization or an MCO. This is notable considering the managed care

penetration in many states.

In 2014, we reported that about 60 percent of Medicaid beneficiaries were enrolled in a comprehensive managed care plan. Furthermore, managed care contracts with states often require the plans to conduct program integrity efforts.

MFCUs generally are dependent on referrals from the states as well as managed care companies to investigate fraud allegations. The proposed rule would allow now MFCUs to access federal funds for certain activities such as data mining activities, as long as they're not duplicative of the states. This is a clarification. MFCUs can conduct an analysis of state Medicaid claims, for example, with HHS OIG's permission to do so in order to identify cases on their own.

It would also allow them to increase referrals on their own through program outreach, such as talking to providers, law enforcement, and the public.

So referrals are still key to MFCU operations, and most of these are already doing outreach and data mining activities, but now it's in the regulation with the goal of increasing referrals and reducing this dependence.

MACPAC is currently conducting ongoing work looking at the strengths and challenges of existing federal and state managed care program integrity efforts in the context of the final managed care rule that was issued this summer.

We're conducting an environmental scan of existing state and federal program integrity practices, and in the summer and this fall 2016, we're conducting interviews with ten states, including five MFCUs, managed care companies, and several federal stakeholders, including HHS OIG, which we indicated oversees the MFCUs.

This work is still under way, but some early themes can be identified, including the challenges in the collaboration across federal and state entities working on program integrity, including challenges in the relationship between the MFCUs and managed care organizations. Similarly, MFCUs generally cite receiving quality referrals from state agencies, but referrals from MCOs are limited and in poor quality.

As I mentioned before, the rule proposes to require MFCUs to certify to the state agency if a referred matter continues to be under investigation and, thus,

warrants continued suspension of payment. However, there's no similar requirement for MFCUs to provide this information to MCOs, potentially creating a gap in the parties involved in managed care program integrity practices.

Finally, the issue of collaboration and communication has come up as a major theme across entities, but it's not just unique to MFCUs and MCOs. These organizations do want to collaborate to assess the same people without being duplicative, but the question is to do that is a challenge. This is just one piece of a larger picture of how various federal and state entities perform their various functions and interact as they work to promote program integrity.

As we noted, the Commission has the opportunity to provide comments on the proposed rule that Kacey discussed by November 21st. We also would be interested in the Commission's thoughts regarding our ongoing work on managed care program integrity and any opportunities for future work in the area of program integrity.

CHAIR ROSENBAUM: Thank you.

So we have a number of comments. We have Kit.

Toby, was your hand up? Andy. Okay. Take it away.

COMMISSIONER GORTON: So thanks for the important work. As always, well done.

I do think that we should comment. I know we're not required to, but I think the gap with respect to managed care is one that needs to be called out and have a light shine on it.

It is true that depending on what state you're in, the plans can work with the MFCUs, and there are examples of it being done well. I don't know that any state can point to a situation where it's always done well, and there are always situations where some plans are better than others.

I will point out that some plans are provider-sponsored. Their parent organization are providers, and that creates a conflict of interest at the level of the plans for participating and program integrity activities, which might involve the people who sign their paychecks, and so there is -- I think there's an opportunity to talk about the referral patterns.

I think the points you raise about pending claims during referrals, that can be very complicated. A plan

makes the referral to the MFCU. The MFCU says thank you very much, pen the claim, and then you never hear back. And you're not allowed to talk to the provider. At some point, you're in breach of your contract with the provider, and so that creates attention which in sort of borderline cases may cause people to hold off on making a MFCU referral or may cause them to try and do their own investigation.

We do hear that sometimes the quality of the referrals, as you've indicated, is not very good. I think that's partly because the plans get very limited guidance form many states and virtually none from the MFCUs in terms of what constitutes a good quality referral. So to the extent that we can tighten up the communication and collaboration, I think that would be enormously useful.

And the last thing that I'll point out in addition to what you said about the transition of now 60 percent of the population into managed care organizations, we're also in the early stages of a huge shift in terms of services moving into managed care with managed long-term services and supports.

The program integrity opportunities in home- and

community-based services are legion, and so having a strong capacity to be looking at those, managing those across a system of managed care organizations with a multiplicity of providers and some fairly substantial potential beneficiary impacts if we don't manage it well, I think it is an important opportunity for CMS to establish a new standard. And I'm a little, frankly, disappointed that they didn't at least take a whack at trying to include managed care in a more meaningful way.

CHAIR ROSENBAUM: Great. Thank you.

I have Toby, Andy, Chuck, and Sharon.

COMMISSIONER DOUGLAS: Good overview. Thank you very much for the work on this.

So I agree with Kit on the managed care needing -- it's concerning, especially when I step back and think of a lot of the issues that I saw around program integrity or carved out services and ability of providers to really kind of skirt -- not having -- since the state didn't have full visibility of what's going on with fragmentation, they can leverage when that happened and substance use services. That happens in dental. So without bringing the managed care plan into it to pull everything together, it creates

that opportunity.

And that's the other area which I wasn't completely clear on the rule. It relates not just in Medicaid but a lot of issues that we saw across Medicaid and Medicare and the intersection of provider program integrity issues that go across the two areas and the ability to communicate both directions and for MFCUs and the Medicaid agency to know what's going on, on the Medicare side, with providers, and I wasn't clear. Is that part of it? Is it a two-way communication or more only MFCU to HHS OIG?

MS. MORRIS: So your question is, Can the MFCU speak to the MCO and the MCO speak to the MFCU?

COMMISSIONER DOUGLAS: No. To Medicare, to really more what's going on in the Medicare program integrity, because a lot of the issues cross over.

I'm not an expert, but what we saw was looking for -- there are ways to deal, whether it's -- as Kit said, on the nursing facility and home- and community-based services. They might be doing issues on the acute side that are Medicare, and that could then be some ways that they might then be called capping beneficiaries and taking

to certain services that are on the Medicare side. And so the same goes on in dental. So it's all these carved-out -- why so much of it has to be a holistic view across all these services, whether it's managed care, fee-for-service, Medicare, Medicaid, behavioral health, all the different pieces. I just want to make sure we're commenting on that.

Maybe I'll just leave it at that.

CHAIR ROSENBAUM: Andy.

COMMISSIONER COHEN: I had a question and a comment.

The question is -- I may have missed it, but I don't think we understand -- I don't think there was anything in the materials to explain why CMS may have -- why the proposed rule may not accommodate the required reporting back to the MCO, and it strikes me that there could be some good reasons. So I just wanted to ask you if you came across any, because I think we can all understand the reasons why it would be a good idea, but I can think of some way it wouldn't be a good idea. And I just wanted to know if you had --

MS. MORRIS: I don't think it speculates. The rule is pretty focused on technical changes for the first

time in about 30 years. So I think it's mostly the goal of it was to clean up the regulation and match it with the statute, match it with current practices. So it just doesn't seem to go there.

COMMISSIONER COHEN: But I would just say before we comment in favor of adding that requirement, I would want to do some exploration of it to make sure that we're catching both sides. My wild guess would be that there might be some concern. MCOs are in contractual relationships with providers, and there might be some concerns that information would be shared improperly with the targets or otherwise, and so there might be lots of ways to address that. But I'm just saying the issue of the role that the MCO plays, it is supposed it play a role on program integrity, and yet I bet government has some suspicions about how -- whether that is uniformly kind of like the case. So I just want to make sure that we explore both sides of it before we decide to comment. So that was my question. Maybe that was comment.

And then, really quickly, I do think one of the big issues -- and I'm not sure this is for comment on the rule, but it is always interesting to me to hear about the

number of times -- the number of ways in which information about program fraud or program integrity issues are not shared across every kind of boundary that you can imagine, and in Medicaid, the most obvious boundary is across states.

There's not a lot of -- there's so much work in Medicare, where the money is all federal. A lot of the Medicaid work is really farmed off to MFCU. They really only care what's happening in their state, and I just wonder about the coordination across states, which is something that I think MACPAC could really sort of dig into, like what are some ways to really maximize that, when most of the parties involved in this activity don't have a big incentive to sort of share information across states or give someone else a tip or lead.

CHAIR ROSENBAUM: Chuck.

COMMISSIONER MILLIGAN: So I'll focus my comment on the managed care part of this, with one kind of story. I think that it's useful to go in the direction of managed care, and full disclosure, I work at a Medicaid managed care organization these days.

But I do want to share kind of one issue

underneath this, I think, from the MCO perspective, which is if a provider is identified as having committed fraud, waste, or abuse, who gets the recovery?

Let me sort of unpack that a little bit. There's some amount of assumed recovery that's built into rate setting that states do with MCOs in terms of baseline program integrity activities that are presumed to be happening or contractually required to be happening, and so there's a presumption that MCOs are getting recoveries by doing program integrity.

The issue can be that -- I've been part of an example where a referral was made from an MCO to a MFCU, and it's through this kind of a process in New Mexico where there's joint activities with the U.S. Attorney's office and federal DEA, federal Postal Inspector General's office, lots of others who are involved in all of this, but the MFCU wanted the recovery from the provider themselves. They're incentivized to have big numbers that they can then sort of send upstream to HHS OIG and say, "Look at everything we did and why we're so valuable," but those recoveries were built into the state rate-setting assumptions for the MCOs.

And so I think underneath this -- just my own perspective is -- one of the issues is if there is identified fraud, waste, or abuse, does the MCO recover that or recoup it based on having expended it, or does that funding go back to the MFCU for their activities and back to the state general fund? That ambiguity in terms of what's baked into the rates and presumed fraud, waste, and abuse activities that are sort of a deduction from the rates is, I think, underneath some of this issue.

CHAIR ROSENBAUM: I have Sharon, Penny, Kit.

COMMISSIONER CARTE: I'd just like to suggest that based on my experience with Medicaid and CHIP fraud that what fraud is easier to identify, just based on you have someone who gets into the system and is able to extract money and it has no relationship to covered beneficiaries or services, but the question is much more difficult when it's really like deliberate mis-utilization. And I just think that the states and the state programs could use more guidance when it comes to things like that.

I've had the experience of spending lots of time and state resources to work with Medicaid fraud, and then after a great deal of time, the case comes to a prosecutor

who won't prosecute or situations like that. I would just say that anything that you could do in that regard would be a help.

CHAIR ROSENBAUM: Thank you.

Penny.

COMMISSIONER THOMPSON: Gosh. I didn't think this would get any conversation.

[Laughter.]

COMMISSIONER THOMPSON: I would just say, on the regulation, the regulation itself, I want to echo Andy's concern about -- I think the reason that -- the regulation, as you've described it correctly, is a very technical, conforming regulation, so a lot of the things that we might think of, first of all, if we even suggested that they -- I think CMS would have a logical outgrowth problem, in terms of incorporating some of those suggestions.

I think in terms of incorporating a specific suggestion around communicating with the managed care plans -- if you could remind me, the managed care regulation that CMS issued said that a plan had to make referrals to the MCO or the state -- and/or the state, whatever the state designated. Is that -- was that the correct construction?

So I'm imagining that what's happening here is kind of the same thing in reverse, which is that by focusing on the state agency, the state agency is the one that has contractual responsibilities with the plans. So with respect to directing the plans, to lift or maintain a payment suspension, for example, I'm imagining that the MFCU is communicating with the state, the state is the one that can -- has the authority and power to direct the plan. Whether the state brings the plans into part or all of those conversations it seems completely to the discretion of the state. But I'm suspecting that that's the reason for focusing on the state agency as the point of communication.

With regard to Medicare, Toby, I think that there is an expectation that by talking with the HHS OIG, which also -- which crosses Medicare and Medicaid, that there would be an opportunity for further coordination on that, in addition to the OIG's responsibilities with directing the MFCU.

So I'm not one for -- you know, I mean, we could write a letter that says, gee, we're generally interested and concerned about kind of how, in the larger Medicaid

managed care world, all of this stuff takes place, and that seems like we could say that but I'm not sure that, in terms of any -- that I would recommend any specific recommendation to this regulation per se.

On the larger subject, which is where we're kind of all going, like there's a bunch of stuff here to talk about with respect to managed care, I'm really looking forward to the staff's report out on this topic. I think the question of who owns the overpayments, whether by fraud or error, I think is a big point of conversation and I think that the staff will have some things to say about that to us, and sooner, I hope, rather than later. And I think that some of the conversation maybe takes place better in the context of that larger conversation, of which I think we can visit this question of communication, do plans understand their responsibilities, are they being armed with the information that helps them to be successful, and what's the appropriate response and reward, and, you know, how do we think about the fraud versus error issues, and so forth. And I think that's the discussion that we need to have around these issues, so that we can kind of see the full picture and range of the challenge.

CHAIR ROSENBAUM: Thank you. We have time [off microphone.]

COMMISSIONER MILLIGAN: I just -- it's more just a factual. So Penny, to your point, the payment suspension holds come to us from the Medicaid agency that we have the contract with, and just one other quick point about this. We're expected to adjudicate the claims and keep track of the amount and report frequently on how much is kind of being escrowed, if you will, in the event that the provider is cleared and then we need to release the funding.

So the directions come from the Medicaid agency and we're still adjudicating and holding the payment, to keep track of the funding.

COMMISSIONER THOMPSON: Yes, and that happens at the federal level with regard to Medicare payment suspension as well. I mean, that is the definition of the payment suspension, which is we still adjudicate the claims. We just don't put out the dollars.

CHAIR ROSENBAUM: Okay. Last word.

COMMISSIONER GORTON: So I would be fine with what Penny suggested and just making a general comment that

it's something that needs to be attended to, perhaps not in this rulemaking but going forward it does need to be attended to. I think it's worth, in staff's future work, paying attention to what Sharon pointed out, which is just because we call it the state attorney general doesn't mean they have prosecutorial authority. In Massachusetts it's the county attorney. In Virginia it's the county attorneys, right, and some of those entities, as Sharon pointed out, are loathe to go after, you know, some of the players who they would have to go after.

So I think that's worth thinking about, and I had some other thought but it escapes me so I won't say anything about it.

CHAIR ROSENBAUM: Yeah.

COMMISSIONER DOUGLAS: I mean, after what Penny said I agree. Maybe there doesn't need to be a comment but I do want to stress, and maybe it's in the future work, just this communication. I mean, from what -- you know, I had first-hand scars and just a lot of bad experience with this.

[Laughter.]

COMMISSIONER DOUGLAS: I usually couldn't watch

Anderson Cooper but I had to watch the debate.

But the issue of communication and it's far-reaching, and I guess it's beyond DOJ and all this, and at a federal level that needs to occur to really deal with this. People who are in this space are not just in the health care space. They're in broader -- these are -- you know, when it gets to criminal activities go on and it needs -- there needs to be better federal coordination. And I just think there's got to be some venue to raise this as an issue, because it's not happening right now, and CMS is hamstrung by it.

COMMISSIONER THOMPSON: And it might be nice, too, in addition to the work the staff is doing, if people are really interested in the subject -- I am excited that people are really interested in the subject -- having CMS and the OIG and maybe DOJ come talk to us during a session, and talk about -- these are not new issues that we're struggling with or talking about, right? These are long-standing, systematic issues about what the current state of their efforts are, what their new initiatives have yielded in terms of any results. I think that could be helpful for us, too, to have a better sense of that.

CHAIR ROSENBAUM: All right. I think we are through. Thank you for a great discussion, actually, and we are now back to CHIP Part 2.

CHILDREN'S COVERAGE RECOMMENDATION – REMAINING DECISIONS FOR COMMISSIONERS: PART II

* MS. JEE: Okay. So we are back to CHIP. We're going to pick up where we left off. We ran through the first part of the straw man from September, in the morning session, and in this session we're going to cover the other -- the remaining components, and we're going to start here with the optional CHIP-funded subsidies.

You will recall that the optional CHIP-funded subsidies would provide states a new state plan option under CHIP, to use CHIP funds to purchase exchange coverage for CHIP-eligible children. Under the new state plan option, states would determine income eligibility for these subsidies up to their state CHIP income eligibility levels.

The straw man requirements was that the exchange plan purchased with the CHIP-funded subsidies has an actuarial value that is substantially similar to that in their CHIP programs, and that the CHIP standard that limits family out-of-pocket spending for premiums and cost-sharing

of no more than 5 percent of family income would apply.

The straw man also spoke to benefits and specifically that the benefits in the exchange plan purchased with the CHIP funds would need to meet CHIP levels of coverage, including for oral health services. The straw man stipulated that the states' approach to these subsidies would promote efficiency and children's coverage, and also proposed a requirement that states provide public notice and comment prior to submitting a state plan amendment to CMS.

And, finally, there would be a federal evaluation of this program, or the subsidies, to shed line on the impacts on coverage, access to care, and affordability for the children who would be receiving the subsidies.

So that's just a recap of what that component is. And the decision for you this afternoon, Commissioners, on this option, is whether children would receive the CHIP-funded subsidies with or without the federal exchange subsidies for premiums and cost-sharing.

There are two options laid out. The first is to provide the CHIP subsidies without the federal subsidies, and that means that CHIP would pay the premiums and cost-

sharing on the exchange for the children. Option two would provide eligible children both the CHIP subsidies and the federal exchange subsidies. This would serve to increase federal funds that are available to cover this population of children. And then to ensure that the CHIP funds are used only to fund coverage for children and not adults, this option would include some sort of firewall, and we'll talk about that.

Relative to option one, option two would be more complex to administer and -- to implement and to administer. Option two would require a change in law to make CHIP-eligible children also eligible for the exchange subsidies, and option two would increase federal spending and reduce state spending relative to option one, again, because the exchange subsidies are fully federally financed.

So let's dig in a little bit on option two. So if both the federal exchange subsides and CHIP subsidies are available, there are some challenges in how the two are coordinated, and they relate -- the challenges relate to how the exchange plan premiums, the enrollee contributions toward the exchange plan premiums, and the out-of-pocket

spending caps, how those things are determined.

So, specifically, exchange plan premiums are set on an individual basis, whereas the enrollee's expected premium contribution and that is the amount that enrollees pay towards the cost of their exchange coverage. That amount is set on a household basis. So the expected premium contribution is a percent of household income, and that contribution applies to the entire household, regardless of how many members of that household are enrolled in an exchange plan. So if you have a household of four, if one person from that household is enrolled in an exchange plan, or if all four members of that household are enrolled in exchange coverage, the expected contribution is the same. It's a percent of the household income.

On cost-sharing, recall that there are cost-sharing subsidies for exchange coverage for individuals between 100 and 250 percent of the federal poverty level of they purchase a silver plan. The cost-sharing subsidies reduce what enrollees pay out of pocket for services by lowering the out-of-pocket maximum limit, the copayments, and the deductible.

In exchange plans with subsidized cost-sharing, the out-of-pocket maximum varies by income. And because the out-of-pocket maximum represents the most that exchange enrollees would pay for the health care services, we think of it as the enrollee's potential financial exposure on the exchange.

And again, out-of-pocket maximums are set at the plan level. CMS specifies the maximum for what they refer to as self-only plans, so that's for an individual, as well as for family plans, and that is basically twice that of a self-only plan.

Okay. So that's a lot of background.

So to establish a firewall under option two, CHIP funds would be used to purchase child-only exchange plans, and, of course, this has implications for premiums and cost-sharing. The expected household premium contribution -- and again, that's that percent of income that exchange enrollees pay towards their exchange coverage -- effectively would be paid twice, once by CHIP on behalf of the children and once for the parents, to be paid by the family.

With respect to cost-sharing, under the firewall,

families with multiple children would purchase multiple child-only plans, each with its own out-of-pocket spending maximum. So if you have three or more children buying child-only plans, the potential financial exposure for cost-sharing would be three times that of the self-only or the individual plan out-of-pocket maximum, which is greater than the family out-of-pocket maximum, which is twice the self-only.

We're going to walk through these things again. I have some graphs and charts which hopefully are helpful.

[Laughter.]

CHAIR ROSENBAUM: And just to stress, we're talking about current law, no changes.

MS. JEE: Exactly.

CHAIR ROSENBAUM: So this is a very helpful analysis of how it would play out under current constraints, which is a different question from whether an alternative set of rules would emerge in the event of difference in potential options for revenue flow into coverage.

MS. JEE: Right.

COMMISSIONER GORTON: And it's also worth noting

that this is not terribly different from what's in place in the exchange plans today. Right? So while it would be exposing CHIP families to this for the first time, there are an awful lot of people who are living with this today, now, like, what, 27 million people. So this is how the exchanges work, and to the extent that we find that complicated, that's the current state.

CHAIR ROSENBAUM: Although I think the overlay here is two different -- essentially --

COMMISSIONER GORTON: There will have to be conforming changes and somebody will have to sit down --

CHAIR ROSENBAUM: Yeah.

COMMISSIONER GORTON: -- and map -- and pencil it out, and wrap some --

CHAIR ROSENBAUM: Yes, that --

COMMISSIONER GORTON: -- absolutely.

CHAIR ROSENBAUM: -- that's right.

COMMISSIONER GORTON: But in terms of --

CHAIR ROSENBAUM: You can get odd results under current law.

COMMISSIONER GORTON: Right. But in terms of the complexity of what you all are describing, this is how it

works today.

EXECUTIVE DIRECTOR SCHWARTZ: This is how it works if you buy a family plan for parents, something other than self-only for the parents, and you're buying a separate coverage for the kids --

COMMISSIONER GORTON: Yeah.

EXECUTIVE DIRECTOR SCHWARTZ: I would presume that now, a family that's purchasing exchange coverage for the whole family is just buying a family plan. They're not buying self for the parents and then a kid-only plan. They're buying one family plan. That's why this firewall creates a problem if you want to keep the CHIP money from subsidizing the parents.

CHAIR ROSENBAUM: Yeah.

EXECUTIVE DIRECTOR SCHWARTZ: It is complex under any circumstances.

COMMISSIONER GORTON: That was -- I'm sorry. That was really the point I wanted to make, is that this is not a new layer of complexity. It's simply another manifestation of the already incredible complexity in the program.

CHAIR ROSENBAUM: Okay.

MS. JEE: Okay. So we're going to go on to a helpful chart.

[Laughter.]

MS. JEE: Okay. So this chart illustrates the interaction of CHIP and exchange premium subsidy -- I'm sorry?

[Simultaneous discussion.]

MS. JEE: You won't be disappointed.

So this is for a family of four, two adults and two children, in 2016. There are some -- you know, we did use numbers to create the chart. They're just for illustrative purposes. They're based on real numbers, but don't get too tied up with those.

Okay. So I'm going to walk through these bars. Let's see here. We're going to show three sets -- three pairs of bars -- one pair for a family at 150 percent of FPL, another pair for 200, and another pair at 250 percent of FPL.

Okay. So the first bar is going to be option one, where it's just to the CHIP subsidy, and then the second bar in each pair is if there's both the CHIP and the federal exchange subsidy. So here we go.

If there was no federal exchange subsidy, and it's just the CHIP subsidy, CHIP would pay the entire amount of the children's exchange premium, and that is shown here on this -- on, you know, this first little part of the bar that I've shown, and it looked black on the bar but on mine it's blue, but on the screen. So that little amount there is the amount of -- the total premiums for the two children on the exchange. So CHIP pays for all of that. Okay. So that's it. There's no federal exchange subsidy. It's just CHIP.

So then the parents -- we have the parents -- so that next little portion is the expected contribution for the cost of the parents, and that's that little part that's a percent of income. It's calculated as a percent of income. So then, after that, the premium tax -- the federal premium tax credits come in and then pay for the rest of the parents. So the bottom part of the bar is the kids and then the first two little -- the top green parts are the adults. So that's for just CHIP.

Okay. So the second bar is going to show the breakout if there are CHIP subsidies along with the federal subsidies. So when both subsidies are available, CHIP is

going to pay the lower of the cost of the child-only premium or the expected contribution for the exchange premium. So, in this case, at this income level, the expected contribution is lower than the cost of the child-only premiums on the exchange, so that's what CHIP pays. CHIP pays the lower of the two.

Then the federal premium subsidies come in for the kids, and then they pay the rest of the cost of the child-only exchange premium. So that's the two bars there, and you'll see that the two bars on the CHIP and exchange column, the combined total is the same as just -- as the first dark bar for CHIP-only. And then the parents, they pay the expected premium contribution and then the federal tax credits come in and pay the rest of their premium, and you'll see that it's the same. The parents haven't been affected at all by using the exchange premiums for the kids. Okay. So that's 150. We're going to go --

CHAIR ROSENBAUM: I'm so sorry. The goal here, though, is to get the whole family covered.

MS. JEE: Yeah.

CHAIR ROSENBAUM: So you're simply just showing us if CHIP allotments were available to make a part of that

family plan cost, versus CHIP allotments playing more incremental role onto the cost of the family plan in order to bring the family plan's value up to CHIP.

MS. JEE: Well this -- no. This is just to purchase the exchange coverage.

CHAIR ROSENBAUM: No improvements, no nothing.

MS. JEE: Right.

CHAIR ROSENBAUM: Just as is, off the shelf.

MS. JEE: Right. So the second column is really to try and create that firewall so that there's no appearance that the CHIP monies are being used to purchase any coverage for the adults.

CHAIR ROSENBAUM: But my question -- actually, I really hate to interrupt in the middle -- but my question is, since our -- since what we're talking about doing, I thought, was, in fact, using CHIP funding, either in its entirety or as in increments, to unify family coverage in the exchange, but subject to the improvements in coverage that we see available in CHIP, why -- this is just -- this is --

MS. JEE: This is for the base plan.

CHAIR ROSENBAUM: This is literally just the

mathematical numbers without any of the things that we were talking about doing. Right?

MS. JEE: Correct.

CHAIR ROSENBAUM: No -- CHIP just being in the mix of the subsidy, as opposed to in the mix of the subsidy in order to buy up the quality of the plan for the child.

MS. JEE: Well, I mean, if you look at the second bar there, the CHIP and the exchange piece, you know, if there were no CHIP, that bottom part -- that bottom dark part would be cost borne by the family. So it's actually -- in this case, it's CHIP paying that amount on behalf of the children in the family.

EXECUTIVE DIRECTOR SCHWARTZ: This just reflects the purchase of the plans as they exist today. This does not reflect any additional costs that would be associated with buying up the actuarial value or benefit improvements, because we don't have data to show those.

MS. JEE: We don't have specific data on that, but we can show you, on the cost share -- the out-of-pocket cost share side of things -- we have another little table on that.

CHAIR ROSENBAUM: Okay.

MS. JEE: All right. So if we move on to families at 200 percent of federal poverty, again, the first column here is going to be just CHIP paying the full cost of the premiums on the exchange. So the dark bar, again, is CHIP. It's going to pay the full amount of the premiums.

So then we have the adults, and the adults have their expected premium contribution for their exchange plan. And then the premium tax credit comes in and pays for the rest of the adults' coverage.

Now, in this case, you know, the green bars look different here than they did in the previous bars, and that's because the expected contribution amount is higher because they're at a higher income. So the enrollee pays more; the tax credit pays a little bit less.

Okay. So if we move to the next column and it's the CHIP and the exchange and subsidies together, we've got the first amount, which is what CHIP would pay. And remember that we said that CHIP would pay the lower of the cost of the child-only premiums or the expected contribution. So at this income, for this family, the cost

of the -- the cost of the child-only plans -- thank you, Penny. No, I'm sorry. The cost of the expected contribution is lower than the cost of the child-only plans.

CHAIR ROSENBAUM: Correct.

MS. JEE: Okay. And so that's what CHIP pays, and that's that dark bar there.

So then the premium tax credit's going to come in for the kids, and it's just a little tiny sliver. It's a little bit hard to see. But that's the part that the federal premium tax credit would pay for the child. Okay? And then we go on and we have -- for the two children, thank you, Marsha. And then we have the parents, and, again, the expected premium contribution is the same. And then the tax credit, the premium subsidy for the parents is the same.

So if we go on to the third bar, it's the same story for the CHIP-only column. CHIP pays the full cost of the premium. That's there. And then the parents, their expected contribution, again, a little bit higher at a higher income level, and then the premium subsidy for the parents.

Okay. So we're going to add the CHIP -- we're going to combine the CHIP and exchange subsidies in the next column, and here we have in this case the expected contribution for this family is higher than the cost of the child-only premiums in the exchange. So CHIP pays the lower of the two, and so CHIP's going to pay the full cost of the child premiums, the children's premiums, and there's no federal premium subsidy for these kids. And then the parents, we have their expected contribution and then the premium subsidies for the parents.

So this is how we envision Option 1 and Option 2, and hopefully that helps to illustrate, you know, the coordination that needs to occur.

CHAIR ROSENBAUM: It certainly illustrates the math. I think --

[Laughter.]

CHAIR ROSENBAUM: I think -- and I just don't want to -- in your extraordinary effort to simplify the math of this, I also want to be sure, which we'll do in the discussion, that we go back to first principles here. What was the purpose of our ruminations, okay? It was not to do mathematical stacking that you must be Joanne to

understand. There is something deeper here, and I think we'll just want to come back to it. But why don't you keep going?

MS. JEE: All right. Just a little bit more math, for which I apologize. And thank you for bearing with me through this.

So here on this slide, we're laying out potential out-of-pocket cost-sharing exposure under Option 2, which is the CHIP and the exchange subsidies together for CHIP-eligible children. We won't go through every cell on this table. I'll spare everybody that. We're really going to focus on the column -- it's the second from the right, and it says, "Reduced out-of-pocket max," and that's representing what CHIP -- the maximum that CHIP would pay. So remember we said that for families at 100 to 200 percent of federal poverty, they might receive cost-sharing subsidies if they purchase a silver plan, and these subsidies have the effect of increasing the actuarial value of the exchange plan by reducing out-of-pocket costs, including the limit, co-payments, deductibles.

So if we look at the column that says the reduced out-of-pocket, or OOP, that first row shows one child, and

it has the out-of-pocket maximum, $2,250 for just on a self-only plan, which would be, you know, a child-only plan for one child. And then we're just going to scooch down to the third row that says, "Other than self-only," which is basically the same as family, and the out-of-pocket max is increased to $4,500. And so you'll see that that family max is twice that of the self-only.

So the point here is that if you have a family with three or more children, under this firewall option, that family is going to buy three child-only plans, and each of those plans has an out-of-pocket maximum. And that's the potential financial exposure on the family for cost sharing.

CHAIR ROSENBAUM: Remind everybody, this is under current law.

MS. JEE: Under current law.

CHAIR ROSENBAUM: As things stand now.

MS. JEE: Correct. So, you know, the federal cost-sharing subsidies are already in the mix here because they've reduced the out-of-pocket, right? And so with CHIP, CHIP would pay whatever the cost sharing is up to this reduced max. So if you have a family of three or more

children, they're each buying a child-only plan; each plan has an out-of-pocket max. So potentially, you know, that family has financial exposure, potential financial exposure, of three times the out-of-pocket max. So it's three times, literally three times $2,250, or the out-of-pocket max for one person.

Now, if you contrast that to if that family had bought a family plan, the family maximum is $4,500, so the out-of-pocket financial exposure for that family is lower, would have been lower if they bought the family plan and not the multiple child-only plans.

VICE CHAIR GOLD: Aren't each of these -- they're all 250 or below poverty, so that the cost-sharing buy-down doesn't factor in here?

CHAIR ROSENBAUM: This is this.

MS. JEE: So if you look, Marsha, on the first column of the table, it has the unsubsidized out-of-pocket maximum. That's $6,850 for one and then $13,700 for other than self. That's the standard out-of-pocket maximum. With the cost-sharing reduction, we've lowered it to $2,200 and $4,500. So that's a family at 200 percent of poverty. We have another chart which we won't go through. It's a

family at 250 percent. The numbers are a little bit different, but the point is the same.

COMMISSIONER COHEN: So I guess I always come back to this fundamental question when we start to talk about this analysis, which is we can make recommendations on statutory change.

CHAIR ROSENBAUM: Right.

COMMISSIONER COHEN: And so we can -- I'm trying to understand what is fundamental to the structural and actuarial pieces of the ACA and CHIP and what is just a recommendation about you never have to pay more than two kids, or --

CHAIR ROSENBAUM: I suggest we let Joanne get to this [off microphone].

COMMISSIONER COHEN: Oh, I'm sorry. She's getting to that.

CHAIR ROSENBAUM: No, no. I think you're totally correct. What I want to do is power through the slides, and then I think we need to take a step back, because what Joanne is showing us is the literal application of current law to two pools of funds. Okay? And so I suggest that we quickly get through the literal application of current law

to two pools of funds, because I think the more important discussion which will guide our work, you know, going forward, is going to be what are we trying to solve here, what are we trying to do here, and, you know, what issues do we need to explore and what changes in law might we need as a result.

MS. JEE: So that's it for the math. I'm done. Now it's Ben's turn.

* MR. FINDER: We'll shift gears for a minute and talk about the new waivers to promote seamless children's coverage. These waivers address your long-term vision for the future of children's coverage.

Commissioners, you said that a hallmark of that coverage is a greater seamlessness across coverage sources, particularly with respect to affordability and the comprehensiveness of benefits. The new waiver option would provide an opportunity for states to take some steps in that direction. And I should note that we've changed a little bit how we're describing these waivers to clarify that this is a new authority separate and distinct from Section 1115 or Section 1332 waiver authority.

As we noted last month, the Secretary of Health

and Human Services would establish state participation criteria to identify states that could participate in this, as well as develop a waiver template to help simplify the application process for states. states pursuing this option would also need to demonstrate that their waiver would not result in losses in children's coverage rates and ensure that Medicaid protections apply for children at the states' income eligibility level for Medicaid.

Federal funding for the waivers would come from Medicaid, CHIP, and exchange funds that states would have otherwise spent on children's coverage absent the waivers. And just as in the subsidy option, Commissioners have stressed the importance of a requirement for a federal evaluation of this approach.

And the last component of the recommendation is an extension of expiring provisions that have been renewed along with CHIP funding in the past. This component would extend expiring provisions through fiscal year 2022. The first component of this or element of this one is that it would extend the state plan option to use express lane eligibility for children in Medicaid and CHIP. The Commission previously supported an extension of this policy

option -- a permanent extension of this policy option for states in an April 2014 comment letter. The element would also extend funding for outreach enrollment grants, funding for pediatric quality measures, and funding for childhood obesity demonstration projects.

Next we'll talk about the implications of the draft recommendation for federal spending.

You received a preliminary cost estimate for the package of recommendations, and I should stress that this is an upper bound. It's estimated to be about $18.5 billion in new spending. This estimate reflects an extension of -- a five-year extension of the CHIP funding, a five-year extension of the maintenance of effort, and a five-year extension of the 23 percentage point increase.

Based on this morning’s conversation, the features that you guys discussed this morning could mitigate this estimate, and we'll update this figure for the December meeting.

A couple of other caveats worth mentioning as well. Aside from the features that you discussed this morning, the estimate is likely to change depending on whatever the specified legislative language is that's

ultimately developed by Congress around the funding of CHIP. And, secondly, this estimate does not account for the proposed Notice of Benefit and Payment Parameters for 2018 issued by the Centers for Medicare & Medicaid Services, which includes a change to age rating factors for children which could change exchange premiums for children. That's not yet factored into the cost estimate, although we would expect the March baseline to include these factors if the rule is finalized by then.

MACPAC is required by our authorizing statute to examine the budget consequences of any MACPAC recommendation, either directly or through consultation with others, and submit a report on these consequences. Typically, we've fulfilled this requirement by obtaining cost estimates by CBO.

It's also worth noting that the statutory Pay-As-You-Go-Act, or PAYGO, requires the new spending approved by Congress be offset by corresponding spending cuts or added revenue.

Finally, the Commission has been asked by majority Members of Congress on our committees of jurisdiction to offer offsets from Medicaid or CHIP when

making recommendations.

Commissioners, we, the staff, are recommending adopting a model that's used by MedPAC in which the Commission would include a list of CHIP and Medicaid offsets suggested by other credible sources with its CHIP recommendation without endorsing any specific offset. Such a list has been included in your meeting materials, and it is not intended to be an exhaustive list.

Next steps. Based on your conversation today, we will take your feedback and input to prepare recommendation language for your consideration and vote in December. Following that, we would publish the recommendation with accompanying rationale and other supporting text in January of this year. And at this point, I'll close and we look forward to your questions, comments, and feedback.

CHAIR ROSENBAUM: Let me suggest a way forward here because we've got a lot of ground to cover in a short span, as we're clearing our heads from Joanne, who was mighty -- I mean, just mighty. So there are really, as I see it, four things on the table that we're going to try and move through quickly.

This morning, essentially, we had a lot of back

and forth about what I think we all settled into as our favorite metaphor for the moment, a bridge -- okay? -- and we had a lot of, I think, convergence on sort of the elements of a bridge.

What Joanne and Ben are now putting on the table is a set of what you might call modifications to the underlying program that we're bridging. Okay? Do we alter the terms of CHIP and, by extension, alter the terms of the tax provisions of the Affordable Care Act, recommend alternating provisions to actually build some flexibility into the combination of subsidies? Do we allow something that we'll call a waiver for the moment? And we may decide that, yes, we want to do that, or we may decide that we need to do a lot more work on this, and it's going to be separated out from our December recommendations, that we think we've got something here that maybe we want to make some recommendations now about the undergirding of the bridge or maybe we don't.

But it sort of goes to follow, if we're building a bridge, that we then should be talking about sort of the thing that's holding the bridge up. And then we have extenders to talk about, and we have this question of

whether we send a list of offsets up.

So why don't we start with what I think are the least complicated, which is the extenders? How do we feel about extenders? Do we want our December vote to include, to address the issue of extenders? And what discussion do we need to have about them?

VICE CHAIR GOLD: Yeah, I would suggest -- I mean, it seemed to me from the discussion earlier that pretty much there was either agreement on all the extenders or those that there was some hesitation, the factual information provided by the comments addressed it. And so I would propose that we just say we're going to accept all the extenders and use our time for the other discussions where I think there's a lot more disagreement or uncertainty.

COMMISSIONER GORTON: So I'm where Marsha is with the exception of I think express lane, we ought to talk about making it permanent and be done with it.

VICE CHAIR GOLD: I'd be fine with that. You know, Toby might be interested, too [off microphone].

COMMISSIONER DOUGLAS: I would agree with what Kit just said.

COMMISSIONER MILLIGAN: I would agree in terms of making it permanent. Just one other part of express lane eligibility, it tends to be unidirectional. So if and when this is the recommendation brought forward in December, I do want to preview a piece of that, the unidirectional meaning Medicaid and CHIP will accept the determinations made by somebody else, so SNAP or so on, food stamps. But a lot of families still have to go in and apply for food stamps, and if it was more bidirectional, a lot of the family burden of applying would be reduced. So I think that's been a defect in how it's been framed all the way along. So I just want to put that out there.

CHAIR ROSENBAUM: Yes. Since our report is to Congress and our report is not necessarily to the committees with jurisdiction over specific programs, there's no reason why we cannot raise issues that would actually implicate other statutes besides the health statute.

COMMISSIONER THOMPSON: Not to complicate, to agree with all that, including permanent express lane, but just to make sure we talk about this, are we also reinforcing prior MACPAC recommendations with respect to

premiums and waiting periods?

EXECUTIVE DIRECTOR SCHWARTZ: From my perspective, that seems to go with a discussion around the maintenance of effort because the maintenance of effort affects premiums and waiting periods.

And just to remind folks that the prior recommendations, which were made in March 2014, were that waiting periods be eliminated, and the primary rationale was that States were already moving in the direction of getting rid of them, and even the States that had them on the books, there are so many exceptions in them.

The second recommendation was that there be no premiums charged to kids and families below 150 percent of poverty to align with the Medicaid statute and also because of the compelling data that we had on families dropping coverage at that income level in the face of those premiums that increased as you went up the income scale.

COMMISSIONER THOMPSON: So does that mean -- and just in terms of, again, getting to what is the recommendation in front of us in December that we would -- irrespective of anything else, that we would reinforce those, or we would say that in the second stage of a five-

year that there be the --

EXECUTIVE DIRECTOR SCHWARTZ: I think it's your choice. I think you can actually, in the recommendation itself, reiterate the recommendation in kind of a bold language, or you can do it simply in the text saying -- when we talk about the MOE being liberalized, these are things that we continue to hold important. So it's your choice.

COMMISSIONER THOMPSON: My view about it -- I mean, I don't think those are liberalizations of MOE. For some States, they would be almost a tightening of what they would already be allowed to do under MOE. So I think they're a separate thing.

Since we've previously made the recommendations, it doesn't feel to me like we have to go back and re-litigate that, as much as reinforce that. While we're in the neighborhood of talking about CHIP, we have previously talked about some aspects of CHIP, and we ought to just --

CHAIR ROSENBAUM: So I think we'd like to --

COMMISSIONER THOMPSON: -- collect that together.

CHAIR ROSENBAUM: Yep, yep, yep. As top-level recommendation. Good. Yes.

So I think that gets us through extenders, and now the next question is, Are we assuming that we are going to be sending a list of possible offsets?

Just to remind everybody, we've been in operation not long enough to have our own self-generated list of offsets. That work is starting now in MACPAC, thinking about ways that we can introduce efficiencies into Medicaid, but there are offsets that have been identified by CBO, by others, and do we assume that we will be sending a list?

Yes. I see a lot of nods of heads, so yes.

COMMISSIONER THOMPSON: I think Congress has the list. So I don't know --

CHAIR ROSENBAUM: I don't mean send a list.

COMMISSIONER THOMPSON: Yeah, we can send a list. I think they have the list.

CHAIR ROSENBAUM: I mean identify. Yeah, yeah.

Chuck.

COMMISSIONER MILLIGAN: I agree, and I like the way that the list was prepared in the materials by identifying the source and time frame. As long as we can make it clear that we are not endorsing any particular

items, I think that is a good approach.

CHAIR ROSENBAUM: Good.

Andy.

COMMISSIONER COHEN: I just want to say really fast -- and I think we all agree with it, but I just want to say it. I think we all intend that if we're going to make a recommendation for an offset, we treat it like a policy, just like anything else, and not just like an offset. So it has to have all the analysis, and that we do hope to have them in the future. Yeah.

CHAIR ROSENBAUM: That is a capability that we anticipate growing. We are not there yet, but it's a long-term aim.

Okay. So this brings us to sort of this deeper discussion of having made essentially bridge-structure recommendations this morning, thinking about whether we're even at a place where we're ready to make a recommendation about sort of the understructure of CHIP itself or whether we feel that we have more work to do, what directions we'd like to move in.

And I would like to get the ball rolling by just stating two fundamental principles that I find are driving

my own thinking about this. The first principle is that for those families who either the entire family or any members of the family depend on the individual market to get them to affordable good quality coverage, so whether you're buying for the whole unit, whether you're buying for your children only, whether you're buying for yourself and your child, that they benefit, children benefit when that ultimate construct of an affordable individual market is thought of in the broadest terms. In other words, that for this, because we're talking about having to buy for some group of people, who vary by State, insurance from a private insurance market -- private insurance markets are actually very delicate things. You can get them going, and they can be strong and flourishing, or they can be struggling.

So, when we think about a child health policy, to me a first principle is that we're thinking about a policy that benefits the children direction and the families they live in. That's number one for me.

And number two is that when we think about steps we need to take to strengthen the individual market for whoever needs it, we shouldn't have to trade off the

quality and affordability of coverage for children to get there. We should be able to -- the way I sort of think about it, as opposed to the movie analogies this morning, we should be able, as a country, to chew gum and walk at the same time. We should have a good, strong individual insurance market for whoever needs it. It should have a test of affordability that really helps everybody who needs affordable coverage and doesn't have it through an employer or through public insurance, and that for children who are deserving of sort of special consideration and structuring benefits, because they don't make these decisions on their own, we shouldn't have to trade off a strong market for that.

So those are my principles going forward, and I think it would help, just to get some discussion about what's driving our collective thinking at this point.

So, Kit. Let's just go right down the list, right down the group.

COMMISSIONER CRUZ: Well, I have a question and a comment.

CHAIR ROSENBAUM: Yes.

COMMISSIONER CRUZ: As most of all -- or at least

I am sort of very confused and conflicted by this, but I have a specific question about that table on slide -- that table on the CHIP exchange premium subsidy interaction.

So what happens when you have a single parent that has an employee-covered plan that is very sort of bareback and inefficient, and he says let you go for CHIP and prefers to enroll his or her children in CHIP because of the comprehensiveness of the plan that is not covered by is employee paid-for plan.

CHAIR ROSENBAUM: You mean where there is no dependent coverage or where there is dependent coverage, but it's not very good?

COMMISSIONER CRUZ: Both, actually. I mean, if --

CHAIR ROSENBAUM: Both.

Under current law, if you have access to dependent coverage, you may be caught in the family glitch. You may not have any choice at all, and that's why I think we should park for just a moment. For this discussion, I think we should park current law. I think we want to erase Slide 6 from our heads, and that's why, in fact, it was the family glitch that was propelling me in my principles.

That if you have to turn to the individual market for any reason, you should have good, quality affordable coverage.

COMMISSIONER CRUZ: Exactly, exactly. Okay.

CHAIR ROSENBAUM: Kit.

COMMISSIONER GORTON: So, first, building on something you said about the fragility of the insurance market, one of the ways to make the insurance market less fragile is to make it bigger and less fragmented, and one of my fundamental problems with the way CHIP is currently designed is we take a chunk of people, and we make them their own risk pool. And that creates volatility and vulnerability in the risk pool that is CHIP, and it creates comparable volatility and instability in the rest of the market.

And so for me, one of the issues is to be able to pool that risk, which in the end gives you a much more efficient approach to the market.

In addition, I think one of the big issues that the families that we've described confront and which I described in my personal situation earlier is these transitions, and for me, a bunch of this stuff -- Joanne's slide, that's stuff which frankly can happen behind the

curtain. If we can get the rule sorted out, you can actually get to a place where the machines can figure out what it is that somebody owes on any given day, and so we don't have to burden families and providers with that. We just say, "Okay. You've got seamless coverage. Let us know what your income is. What is your MAGI today, and how many people are you covering? Here are the rules. Okay. Here is how it looks for you," and we are going to try to make that affordable.

So, again, for me, that's one of the reasons that I am interested in moving beyond the current construct, which I find unsatisfactory in many ways.

The last piece I will say is many of my colleagues on the Commission have commented today and in the last meeting in September that they were skeptical that we would be able to move beyond the current construct, and it's not that I don't share that skepticism. I just don't feel like we can be defeated by the inertia of the past. It's our duty, in my view, to try and describe a future that people could move to.

So I will try and figure out a way to wrap my head around a five-year extension, but for me, if we're

going to talk about a five-year extension, then we've got to begin at least to lay out some of the broad-brush strokes of what that future might look like.

Part of the issue, the failure of the last two years, is that nobody was thinking about what came next, and so I guess what I'm saying is, if I'm being asked to sign up for a five-year extension, then it ought to at least include pointing at the moon of where we could go and creating a pathway to get there. And it seems to me the waiver to provide comprehensive children's coverage or however staff cleverly crafted it, that that gives States a tool whereby -- not every State, but some States will begin to move in that direction, which will enable us to use our construct of States as laboratories to lay out what are the options. And it will look different in Oregon than it will in Massachusetts, because things always do, but at the end of the day, when we get two or three years in, allowing for rulemaking, then there may be some models that people could say, "Okay. This could work."

The Arkansas people may come up with something new and clever that people are willing to take a try on. If we don't open the door for some experimentation, for

some flexibility, for the Secretary with everybody under the [off microphone] lights looking closely at what he or she will do, if we don't create some State flexibility, then we can guarantee -- it's a self-fulfilling prophecy. With no flexibility between now and 2022, we will be in the same place in 2022.

So, for me, these pieces are very, very important, and I would just ask my colleagues to not get bound down in the fact that we can't describe it to the deepest level of detail that we all would want that would eliminate the flexibility, but I do think we have a responsibility to issue a call to action and to point in the general direction of where people might go.

CHAIR ROSENBAUM: Stacey.

COMMISSIONER LAMPKIN: I will just be very quick.

Trying to just say where are we coming from on this high level, for me, this is about given the flexibility for experimentation while we wait for a permanent solution, and so for me, the big deal is whether we design the recommendation in a way that's practical and can work. That would be the guiding principle.

So, if we need those extra dollars associated

with option two versus option one and it can be done, but it's going to take that extra money to be able to make it practical for States, then that's where I think -- it's what practical.

CHAIR ROSENBAUM: Yeah. I think it's also worth just noting as an aside that deciding we want to go with some sort of a real recommendation in December to allow a new kind of demonstration effort that would loosen up the requirements on both the exchange side of life and the CHIP side of life, that's a very different order of magnitude from making recommendations that would permanently change the exchange side of life and the CHIP side of life.

COMMISSIONER SZILAGYI: I think what you were asking is for principles about what the exchange -- what that would look like, and I'm not sure I heard you say, but I think maybe you meant it. It's that the benefit structure is not measurably different or worse under the exchange. Maybe that's what you meant when you said quality.

CHAIR ROSENBAUM: What I'm saying is you shouldn't have to trade off the quality of coverage --

COMMISSIONER SZILAGYI: Right.

CHAIR ROSENBAUM: -- to get a stronger risk score.

COMMISSIONER SZILAGYI: And practicality.

CHAIR ROSENBAUM: Right.

COMMISSIONER SZILAGYI: My other point was exactly what Stacey said. It was practicality, sort of simplicity, the Patty Gabow test.

CHAIR ROSENBAUM: Leanna, did you want to --

COMMISSIONER GEORGE: I'll wait until last.

CHAIR ROSENBAUM: Okay. Chuck.

COMMISSIONER MILLIGAN: So I want to align myself, I think, with what Kit and Stacey said. Here is my concern about some of this. I think that if the State experimentation will result in more federal tax credits in a given State than otherwise would exist but for the waiver, it creates -- setting aside the federal congressional appropriation and tax piece of that, it can create the effect of federal taxpayers in one State supporting, financially supporting the demo in another State.

I'm sorry, but, Joanne, that slide that was so complicated, I do want to sort of stay here for a second.

Do you mind taking us back there?

So I want to just go into the middle column, the 200 percent FPL. The effect is that -- it's a small number in this particular example, but that 120 of federal premium subsidy for the child only, that's being supported by federal taxpayers in a state in this example where the kid -- there's CHIP funding available for the kid at 200 percent of poverty. There are States where kids at 200 percent of poverty are not eligible for CHIP. The State doesn't take their CHIP eligibility level that high. So the State that has CHIP up that high, that has those CHIP dollars to spend, can use this option. A kid could be at 200 percent of poverty in a different State and not have access to CHIP at all, and the State where that child does not have access to coverage in CHIP at 200 percent of poverty, the taxpayers in that State, including that child's parents, are supporting this demo in this State.

So I do think that, all to say, I support where Kit took us. I support the notion of States as last. I support the notion of this new waiver that would have Medicaid, CHIP, and the Section 1332 implications, but I think that the federal tax credit cross-subsidies across

States paying for that demo, to me, risks further exacerbating inequities across States about CHIP. That's the point I want to make.

CHAIR ROSENBAUM: Sharon.

COMMISSIONER CARTE: My thought is a continuation of a question that we took up this morning about the quality of the benefit, and what I wonder is if -- I like Kit's analogy about let's make sure we're shooting towards the moon instead of waiting for the Secretary to do a survey of all 50 State markets and determine what their actuarial value looks like for plans. Would it be possible to set -- I'm not sure if CMS could do it through rule or regulation, but to have CCIIO look at all the silver plans and the actuarial value of where they stand and have it benchmarked according to each State's CHIP program, just as a --

CHAIR ROSENBAUM: So that you would have a comparison.

COMMISSIONER CARTE: Right, that you would have an ongoing comparison, and the plans themselves would have something to look at as they are creating efficiencies, as they are now. Then they can see how far they have to go or

how much they've gained.

CHAIR ROSENBAUM: Toby.

COMMISSIONER DOUGLAS: Don't want to be a broken record. Definitely echo Kit's vision and think it's essential that we lay that out because I think it really gets into why we see this State waiver across Medicaid, CHIP, and exchange as so important to test out and where we want to go.

On the subsidies piece or the premium assistance, as much as we seem to be spending on this slide, I think it really is important illustrating the problem of the current premium assistance, which is there's no way a State would meet that cost-effectiveness test. The amount that you have to put towards the subsidies is far more than what States are spending on CHIP premiums today, so they couldn't do it.

So I do think this is an important kind of illustration of the problem, solution that we're trying to say as, okay, get rid of that cost effectiveness because we believe in really testing out allowing children to be with their family and the exchange to drive that approach to coverage in a long-term vision.

It does raise a question to me, and this is probably a CBO analysis, but given the size -- and I know these are illustrations, but I think they must be somewhat correct illustrations -- that's a lot of money. So then it gets to the question of will a State be able to -- will this eat into the rest of the -- the allocations that States get, they haven't been hitting them, but are we going to make sure there's sufficient allocations that they can test this approach without impacting and capping out their total dollars because they're putting so much towards the exchange? Is that making sense?

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I have some numbers that would shed some light on it --

COMMISSIONER DOUGLAS: Okay.

EXECUTIVE DIRECTOR SCHWARTZ: -- which is -- and, Ben, you are going to help me out here -- right? -- go off the rails.

So, for 2016 -- so forget about the news we heard this week about 2017 -- CBO said the average federal spending per CHIP enrollee was $2,200, and that includes the bump.

Our estimate is that the second lowest-cost

silver plan premiums were about $1,600 for child-only coverage, so $1,600 versus $2,200.

What we can't -- it is not really an apples-to-apples comparison, so we can't -- that doesn't include what it would cost to buy up the coverage, and also, we don't know what the cost of a benefit wrap would be. But, nonetheless, we're looking at $1,600 to $2,200. It is not an insignificant amount of money.

Also, there's a lot of variation. This is an aggregate number, an average number, so the cross-State variation, either due to CHIP or due to other markets is not there.

But I think to this question about is there enough money in there to do it -- disregarding this -- to do it, it suggests to me that it's an idea that's at least -- there's more math that we could do, hopefully less confusing math. It's not completely lacking in credibility.

COMMISSIONER DOUGLAS: Well, it doesn't also include the next slide for the out-of-pocket to buy it. That's what I understand. It's the combination --

EXECUTIVE DIRECTOR SCHWARTZ: Let's move off the

slide, then.

COMMISSIONER DOUGLAS: Yeah. Okay. Enough said.

CHAIR ROSENBAUM: Andy.

COMMISSIONER COHEN: I don't want to repeat what everyone else has said. All of the things that I think are good about this approach have been said, and I think the thing that I want to get to is this issue, which is that, as we move forward, I just want to make sure that we get a little bit out of the siloes of the programs. We're practically at 100 percent match for almost everything that we do. It's all federal money. It is very heavily federal month, and it moves around in different ways, depending on your risk pool, depending on which slice of the population you're looking at, et cetera.

So I just want to make sure that we don't leap to sort of conclusions about costs of things based on which slice we looked at in a given moment. It's a big body of analytic work to sort of figure out how it could work with interactions over time, but I kind of think that is the body of work that needs to be done. I have the sort of dummy's view that I'm pretty sure it works out because, at the end of the day, there's going to be some cost

differential because of like your delivery systems, probably. And it could work out differently in different States between what happens in CHIP and what happens in the exchange, but at least you know what are the costs. You can figure out where the cost differential comes from, and it's not because you grouped one group over here and left another group over here and you're not really comparing apples to apples.

I also have the dummy sense that there's a lot of ways to make this seamless. There's a lot of back-end calculations and other arrangements that can be made between different payers to make this seamless to the consumer, and I think that that is what this is sort of all about, is to eliminate these transitions and other issues that make it so complicated to people, and government should really sort of take care of that complication, especially when it's paying for it, no matter how you slice it.

So, anyway, I just want to make sure that our analyses take the whole universe.

CHAIR ROSENBAUM: And to that point, your point about the holistic thinking at this point also should

inform us as we think through, well, if we wanted to go down this path either nor or later, what kinds of holistic elements would we build into this new flexibility.

Sheldon. Penny.

COMMISSIONER THOMPSON: Yeah. I think there's been a great discussion here, and I completely agree that if we think that we're building a bridge to something, there ought to be some interim step to evaluate and refine whatever concept that we could have in mind.

I was trying to think about, you know, building on, Toby, your point that really the State option is premium assistance without cost effectiveness. Is that what we're saying, that really that option ends up being --

CHAIR ROSENBAUM: Yes, that's right.

COMMISSIONER THOMPSON: Okay. When CBO scored the package, did they assume that the option included cost effectiveness? We weren't explicit about that, right?

MS. JEE: We were --

VICE CHAIR GOLD: They assumed limited take-up, you said last time.

MS. JEE: They did assume some limited take-up, mostly having to do with sort of the ramp-up and things

like that, and the take-up comes a little bit later in the period.

I don't want to say the wrong thing, so I am probably going to have to double-check that.

COMMISSIONER THOMPSON: I was trying to kind of pull this apart a little bit and think about why existing authorities don't do the job. We talked a little bit about cost effectiveness. Fund segregation is another issue where people are concerned about using funds allocated to certain programs to subsidize coverage that is purchased by other programs. But that is an existing problem.

CHAIR ROSENBAUM: Exactly.

COMMISSIONER THOMPSON: I guess I question whether or not we should perpetuate that, given some of the things that we appreciate and all the reasons why people have created those kinds of structures, so lower-income people aren't subsidizing higher income, et cetera, et cetera.

Premium assistance has never gotten the kind of widespread adoption that some people might have expected or liked because of issues associated with administering those programs, issues for the beneficiaries involved. When you

consider wrap and so forth, those are not easy things to consider.

There's an overall budget neutrality question here. Are we saying that somehow we're calculating across program budget neutrality, and are we saying that programs can subsidize -- savings from one program can be used to support spending in another program, which has also been a longstanding issue of debate?

So I think those are all issues for why we might propose something different that overcomes some of those challenges, if we really want to try to create a single risk pool, a single approach to coverage among populations, and so I'm just wondering whether or not really -- in terms of promoting the State option, I think that has all sorts of complexities and difficulties.

It may be that what we really want to see people expend energy on is the true demonstration that has certain qualities and that is not subject to some of these administrative or management or budget controls that impede the current authorities, which have a lot of flexibility in them but still have problems in delivering to what we have in mind.

CHAIR ROSENBAUM: Well, and, particularly, if we are thinking of something which we seem to be sort of sharing among ourselves here, that could be expected to have spillover effects. When you merge two insurance markets together, you're going to get effects, as the Arkansas demonstration, for example, has shown. There's hints of sort of spillover from what they did, their Medicaid decisions onto their subsidized insurance market. And that's to me a real reason to allow some level of true, much more flexible demonstration than we can get under current law, and it also may mean that whatever we're going to recommend in December, we're going to go back and do some more work in the winter and send the second recommendation up to Congress. We don't have to be on the same track for everything here, and yet we seem to be sinking our teeth into something that, as Kit has pointed out, is moving us, is showing and demonstrating the sort of direction we all sort of feel we might like to move in.

COMMISSIONER THOMPSON: Just one more. I think the idea of having legislative language, which identifies the purpose and the factors that need to be considered, would allow us room to provide some additional support to

the continued development of that concept, and then I just want to say premium stacking. That was the other thing that I wanted to mention as one of those problems that should get thrown into the mix here for a solution.

CHAIR ROSENBAUM: Alan.

COMMISSIONER WEIL: I want to align myself strongly with Kit's opening comments, and I think it also helps us with respect to the MOE issue.

I will say 12 short years ago, I wrote a two-page piece in "Health Affairs" proposing this vision, and you can see how effective it's been.

[Laughter.]

COMMISSIONER WEIL: But, at the time, we had only 9.3 million uninsured children, and I thought we could do it then. Now we have 3.5 million, and we really ought to be able to do it now, so I hope we can.

It is interesting how the discussion has evolved. I guess I want to put something out there that maybe, Sara, was what you just referred to, but I was getting nervous as I listened. My personal view is that I would avoid at this stage using the term "waiver."

First of all, I have seen the evolution of

thinking about Section 1332, which now are going to cure everything that ails the health care system. The term evokes lots of things, some of which I think are consistent with what we're trying to do here, but some of which are quite inconsistent. There was an earlier discussion of secretarial discretion.

I think the other thing that really affects me, and it goes back to my vision, which may or may not be aligned completely, Kit, with yours, but as I said earlier, half the kids have private coverage. And when you talk waiver, you sort of write off the private sector.

What I really think we need is an in-depth work group that doesn't necessarily need to be convened under the auspices of MACPAC. I don't feel strongly to grapple with these issues and come back with models that meet these tests that push, maybe push people's comfort zone with respect to budget categories, with respect to assuring that no one loses anything because we wouldn't want to touch anything.

I guess my point is I want creativity, and I'm a little worried that the language of waivers is no one shall do worse, and it will be designed like this. I'm afraid

that sends the wrong message.

I do want to touch head on to Chuck's comment about interstate equity, which although I often agree with you and this thinking, I don't think this is where I would pick that battle.

First of all, as we've discussed, the money is overwhelmingly federal already at this point. Relative to the interstate inequities in Medicaid, this pales in comparison in terms of dollars.

But most important, I think if we are looking -- I think at this point, we're looking for models. We're looking for -- forgive the overused term -- "out-of-the-box thinking." We wouldn't have the ACA if we didn't have Massachusetts health reform. Did Massachusetts need the money from the rest of the country? Probably not. Would they have done it without the money? Probably not.

I guess I think we're at a point where if we can get some creative thinking and early adopters at the State level, I'm willing to give on the interstate equity for the thinking that the country will learn. That's a tradeoff at least I would be willing to make.

CHAIR ROSENBAUM: Brian.

COMMISSIONER BURWELL: So I think the two new options are essential to our recommendation. I'm even thinking that there should be incentives for States to move to those two options. So I'm thinking something along the lines of not only does it not have to meet a cost-effectiveness test, but there's additional federal money that goes to that.

I thinking maybe, okay, a two-year MOE and a 23 percent bump, but then that goes down. But if you have one of the new waivers, you get additional federal money that you otherwise would have lost.

So, in terms of scoring and assuming take-up rates, you could somehow assume the money from the FMAP reduction goes to the new options.

I'm also thinking that the new options could be a seven-year initiative. It takes two years to do anything at CMS, so they would get five years on those options from the time that they started. I don't know if we even want to go that far, but --

CHAIR ROSENBAUM: Well, you know, the thing I started wondering as we went around the room for what I think is one of the best discussions of child health policy

I have ever heard in 41 years -- I mean truly. It was a discussion --

VICE CHAIR GOLD: Can I still --

CHAIR ROSENBAUM: You can, absolutely.

[Laughter.]

CHAIR ROSENBAUM: But one of the things -- and then I'll turn to you, Marsha, and I certainly don't mean to but you off. But we could also think about -- we can also think about making our recommendations in two groups. We can make the recommendations that are absolutely essential to get up there fast because there is just this funding cliff that is coming, and they may move really quickly.

There is no reason why we couldn't decide to put a work group together and by February send a letter. It doesn't have to be in a report. We could send a letter to Congress making an additional recommendation.

So I raise this only to underscore. There's nobody up there who's said to us everything we're recommending, we have to recommend by December 16th or we have no chance at a recommendation. That's all.

COMMISSIONER BURWELL: But I think there's a

downside to --

CHAIR ROSENBAUM: By splitting it.

COMMISSIONER BURWELL: -- recommending an extension without the options that's tied to that.

CHAIR ROSENBAUM: Right.

COMMISSIONER BURWELL: The new options.

CHAIR ROSENBAUM: And we could signal that we want to send something else.

Marsha.

VICE CHAIR GOLD: Okay. Well, I started to think about what I wanted to say as I was listening to people, but starting off at your first principles statement. And I was trying to think about my first principles. This is a little different than the way people said it, but I think it's very consistent with what Kit was saying and a lot of other people were saying. So I don't think I'm off.

I'm dealing mainly with a CHIP-Medicaid-exchange interface. Employers is important. Too complicated. I can't deal with that right now. And, ultimately, where do we want to go?

My view -- and I think this is what you were saying, Kit -- is that the kids who qualify for these

public programs, whether they're privately provided insurance or through Medicaid, kids with equal incomes should have relatively equivalent benefits and those benefits in terms of cost sharing or other things. So this discrepancy -- I think that's the one you've been pointing out -- between if you're in CHIP, you get this -- I mean, I looked over there. I didn't realize how much the cost sharing was for that income. That's high.

In general, my sense is that I'm not comfortable -- or I think, ultimately, or I hope, ultimately, some of the level of cost sharing in the exchange overall will be improved upon because I think it's inconsistent with the goals of the program.

Absent that, kids coverage seems to me a particularly important one, given the strong evidence of what CHIP's coverage has done, that that's a good place to start. There's more consensus there than other things.

So what I'm thinking is that the point of a demonstration is to give us some idea of if you have -- maintaining the CHIP level for now, what can you buy? What does it cost under the exchange to get that? What different packages could you create? So that would be a

useful demonstration. I can't tell if it requires extra money beyond the bump money or not.

My personal sense is that sort of keep things simple. I don't know why we'd want to get into the ACA if we didn't have to get into the ACA. It's like very difficult, and I'd rather -- that's why I'd rather see this experimentation funded under CHIP or under a new pile of money or under some authority, innovation waiver, something -- well, that can't do benefits, but something that lets us test it without -- to get off the ground more quickly and see what this is. Ultimately, it's going to need to have the waiver money. So that's my sense. It's like how do we get this going.

I should also say that I kind of hope that we'd have a minimum standard plan across the country like the exchange is now. I mean, I'm not sure what we want is to re-create totally different sets of benefits in different States. There should, at a minimum, be some bottom that it doesn't go below, and so that's sort of where I'm coming from. And I think it's consistent with some of the ways people were talking about it, but I'm curious.

EXECUTIVE DIRECTOR SCHWARTZ: Did I mention that

Joanne is going to Japan in January?

[Laughter.]

CHAIR ROSENBAUM: For the next six or nine months. Gustavo has a question.

COMMISSIONER CRUZ: I have a question, yes. Somehow I think we have veered away from the discussion, or I didn't get what we're trying to do. We were discussing the CHIP-finance subsidies. Are we saying that we are going to then weave that into the waivers as one of the possibilities of the waivers? Are we not discussing it at this point and deciding to do it at a later date, or what?

CHAIR ROSENBAUM: So, I mean, this is something for us to contemplate a bit more, although we are at the time now.

My own feeling, listening to the room and listening to this discussion and listening to how much convergence there was, is that we as a Commission, meaning us guys and the staff guys, have some more work to do. It is now, as we would say, *erev* of Thanksgiving, soon to be *erev* of Hanukkah and Christmas and all the other holidays, and Kwanzaa, and my own view, having listened to this discussion, is that we have in the course of an hour

outlined for ourselves a really important piece of developmental work that I think we'll need time into the early new year, and yet would do exactly what we were all sort of grasping for this morning, which was we're building a bridge, but, you know, it's a transitional thing. What's the transitional thing? We've essentially put ourselves into a position where we have some responsibility to say what that transitional thing or the underpinnings look like and whether -- you know, how it would be structured, how it would be run. Can you run it in the confines of current law? Would you need new flexibility?

And I for one don't think there's any harm in our transmitting to Congress our recommendations in two phases -- the first phase being the immediate things. I realize that there is some real value to hooking the two together, but you want to be sure, if we're going to carry along an important set of recommendations having to do with what we'd like to open the door to, that it's as well thought out as the first set of recommendations.

And so I think one thing for us to discuss a bit more is whether we feel somehow under some sort of huge time gun to get everything in December or just break it in

two, work --

VICE CHAIR GOLD: What's this?

CHAIR ROSENBAUM: This afternoon's discussion, not the extenders, not the offsets, but the discussion about whatever we're going to call this --

VICE CHAIR GOLD: But the five years is still in the first.

CHAIR ROSENBAUM: That's the morning. That was the morning's discussion. But the discussion we've had now for the past hour, we got extenders out of the way, we got offsets out of the way. And so now this issue is this thing we're all beginning to formulate together. Do we give ourselves another month or two of discussion about that and then send a recommendation? I suppose it could be that Congress could act so quickly that anything else we had to say on the subject, you know, went up -- was just not timely. I don't think so. I think if we decided to send a second recommendation in the winter, we would be probably timely.

So that's my long response to you, which is I think we've got a timing issue here more than a directional issue at this point.

COMMISSIONER GEORGE: I just wanted to comment slightly on the chart that no one seems to like.

[Laughter.]

COMMISSIONER GEORGE: But, I mean, I was running the numbers, and just thinking about, you know, my situation and everything else, at 250 percent we're looking at 8.2 percent family -- or contribution, thank you, toward the program. And when you consider a lot of these at 250 percent, these families may not qualify for housing assistance, may not qualify for SNAP and all these other programs, that really eats into the budget. And I really want us to remember that as we go forward and we're considering what kind of recommendations we're making.

CHAIR ROSENBAUM: Great. Thank you.

COMMISSIONER DOUGLAS: I just want to make sure I understand what you're suggesting because -- and especially with Kit leaving the room. Breaking these apart, part of this, you know, there was a coalescence around the vision, and the two go together in essence. So if we break it apart, I'm afraid that we would lose that, really the compelling vision that we're trying to set with not just the same old five-year extension.

CHAIR ROSENBAUM: Extension, right.

COMMISSIONER DOUGLAS: So I didn't know what you were saying.

CHAIR ROSENBAUM: And I'm happy to [off microphone] didn't mean to say, but my only concern is simply one of the work that it will take just to sort of get the language the way we want the language of a recommendation to be voted on in December. Do we want a little bit more staffing work? Do we feel that we could shape a recommendation? If we feel that we can shape a recommendation, then by all means. And that's really the question.

COMMISSIONER THOMPSON: Well, so exactly to that point, is there a possibility for establishing a desire for a demonstration authority for a particular purpose of testing a thing for which there could be planning grants for states? There could be work for -- you know, there could be some funding for states to develop models rather than necessarily putting that all on --

CHAIR ROSENBAUM: So high enough level [off microphone].

COMMISSIONER THOMPSON: Like I'm trying to think

about whether there's something that represents that desire to move, creates the authority in the event that things move fast, and if we don't have all the details, we haven't missed the boat.

CHAIR ROSENBAUM: No, I think that's a wise idea, very much like --

COMMISSIONER THOMPSON: And then still allows us to continue to work and extend and refine some of those concepts.

CHAIR ROSENBAUM: Get the authority on the books [off microphone]. That might be a very nice way of sort of at least including it in December without having to scope it all out to a point that we just can't do at this point, not that fast.

VICE CHAIR GOLD: The one thing, I think, that -- the issue -- for CBO to score it, we have to give them enough details that either it's not relevant -- I think you could do it by planning grants or by assuming for now it's CHIP money, but ultimately it could be some other kind of money, or something like that. But it needs to have -- it can't have some of these unknowns that make it hard to score at the-- but I'm generally agreeing with Penny.

COMMISSIONER THOMPSON: Right. But isn't that -- I mean, that's what they deal with all the time, like there are some things that are hard to score? So, I mean, I wouldn't want to see us kind of go in a direction and say some things so it's scorable and then regret it later.

CHAIR ROSENBAUM: We could be -- give some certain on -- at least a ballpark on the planning grants, and note that depending on what comes forward, we're giving the Secretary of HHS, along with actually -- because of the way the law is structured, the underlying Affordable Care Act, I mean, it may be the Secretaries of HHS and Treasury together that would have to essentially move on a demonstration, but without the hamstringing that you identified before.

All right. Public Comment time. Any comments?

PUBLIC COMMENT

* MR. CROSS-CALL: Thank you. So my name is Jesse Cross-Call, Center on Budget and Policy Priorities. we did submit some comments based on the meeting last month or the month before, so this is all in more detail there.

I just wanted to say first I very much support making express lane permanent, and just the second part is

on this conversation about the waivers. I would very much urge some caution about getting sort of too far ahead of where the conversation is just yet on this. You know, it's hard, I think, to work off of two slides and to really figure out what this idea is based on the two slides. But, you know, the discussion seems to be about kids' coverage rates, and, I mean, it's hard to figure out if this is all kids or just the kids covered by the waivers. That's a detail that matters. But then also what does that coverage look like? You know, it's about -- right now it's just about coverage, but how comprehensive is it? What does it do for kids who have special needs? What does it do for kids with low incomes?

And so I appreciate the desire to give states flexibility, but as has been said, that can be interpreted many different ways. Thank you.

CHAIR ROSENBAUM: Thank you.

MS. WHITENER: Hello. Kelly Whitener again from the Georgetown University Center for Children and Families, and I would just echo what Jesse just shared about urging caution on thinking through how to do some sort of innovation in this space. I definitely appreciate the

Commission's dedication to wanting to see more equity across the country and wanting all children in similar financial situations to have access to the same scope of benefits and the same affordability protections, and that's definitely a value that we share and something that we're spending a lot of time thinking about.

But getting there is very difficult, so I just would underscore that caution and thinking about how to best achieve that goal, what types of parameters you'd want to put around it. There has been a lot of work done on premium assistance, much of it by my boss, and I'll be happy to share that and submit it for the record on how that works and some of the challenges with those different models. There's also been some surveys -- I believe done by the Kaiser Family Foundation, but I couldn't find it quickly in Google, but we'll send that as follow-up as well -- that shows what are families most interested in in these situations, and they're actually not that interested in having all the same coverage. They're interested in having coverage they can afford.

So just underscoring, you know, what it is you're trying to achieve as you explore some alternative model and

thinking about how best to achieve that without kind of going backwards on some of the things you've achieved already and some of the principles you've already outlined. So we'll be sending some additional materials on follow-up to help inform this discussion, but just appreciate your interest in it and taking some due diligence and caution in what you might propose in terms of waiver authority.

CHAIR ROSENBAUM: Any other comments

[No response.]

CHAIR ROSENBAUM: Well, I think we can take a break for five or ten minutes and come back.

Oh, yes, I'm sorry. We are going to make one minor change -- not a minor change. Have we talked our way through entirely the --

EXECUTIVE DIRECTOR SCHWARTZ: We are about 15 minutes --

CHAIR ROSENBAUM: Yeah, so we're going to try and go ahead with the schedule as it stands. At first I was thinking we might take one of the items off the schedule, but I think we'll find we'll just go for an extra 15 minutes at the end of the day.

[Recess.]

CHAIR ROSENBAUM: All right. We are reconvening, only a little bit behind schedule.

So just to remind everybody, we are now talking about Medicaid prescription drug cost containment and whether cost containment efforts can be improved. Jane, the floor is yours.

CAN MEDICAID PRESCRIPTION DRUG COST CONTAINMENT BE IMPROVED

* MS. HORVATH: Thank you, Sara. Thank you, everybody.

I am going to try to move through this very quickly. You have a lot of background materials that I'm not going to be discussing today in the slides.

Okay. While we're getting -- anyway, we're here today to talk about Medicaid prescription drugs and we're going to talk about the drug benefit some, and then the rebate program, the Medicaid drug rebate program, in detail, with an eye to first comparing Medicaid to the commercial sector, sort of the cost containment -- drug spending cost containment tools that are prevalent on the commercial side, and comparing that with Medicaid programs, and then looking at if there are any options for possibly

improving the drug cost-containment aspects of the Medicaid program, and soliciting your feedback on some ideas, looking for new ideas, and then any recommendations you have for any further work in this area.

And I just wanted to give a caveat, before we start, is that this is like a really complicated area, or at least I find the whole sort of prescription drug market very complicated. It has lots of aspects to it, lots of components. And for the purposes of today's discussion I'm going to be speaking at a very general level, and not providing a ton of detail. So if you're thinking like I missed a detail, it's because I did miss a detail, but I'm sort of choosing not to, like, dive in the weeds in every place along the way, just so we can sort of -- I'm trying to make sure we all understand some basic concepts and basic mechanisms in the marketplace.

So, and this was a chart that Chris Park produced earlier this year or late last year, and I just wanted to show it again to you all, to make sure we sort of understand sort of the basic trends in the Medicaid drug rebate program. And these stacked bars are fee-for-service in the dark, and then in the lighter are managed care. And

so it's total drug spending, from the drug rebate files, year on year, and then the side chart, the gross and the net. So the net shows after rebates what's going on. I think the takeaway point from this slide is that rebates provide very substantial relief to Medicaid programs on their drug spending and do so on a fairly consistent basis.

So here are the four types of Medicaid rebates that are in statute or under state authority, just, again, so that we understand them in brief and how they operate. So the basic rebate in the Medicaid program is the AMP rebate, the average manufacturer price rebate, and that's something -- the average manufacturer price is calculated by each manufacturer for their drugs, and it's based on a bunch of prices in a certain part of the market, which I'll show you in a minute, and it's a rebate on 23.1 percent of that price, sort of every unit dispensed of a product.

Then there's the best price rebate, and that is delivered to state Medicaid programs to the extent that there is a price in the marketplace, the broad marketplace, that exceeds 23.1 of the average manufacturer price. So that would become a best price and then Medicaid agencies would get that best price.

And then there's the inflation penalty add-on, is what I sort of term this, and that's a separate add-on rebate to a particular product at a particular time, when a price increase on that product in a quarter exceeds the growth in the CPIU. And I would point out to you that it's the CPIU, CPI Urban, as opposed to the CPI Medical. So the important point there is that CPIU is pretty low bar, in terms of hitting it and triggering that inflation add-on rebate.

And then there are state supplemental rebates, and these are sort of side rebates that states negotiate with manufacturers, and almost all states have supplemental rebates. Some states actually sort of aggregate their pooling, their lives, to create sort of a better basis on which to negotiate with manufacturers as a single sort of state unit around different products. And states use these supplemental rebates often as leverage with manufacturers to create their preferred drug lists. So you might find that where there is a supplemental rebate agreement in effect, that product is on the state's preferred drug list, and it's a form of states sort of gathering the kind of marketplace leverage that they can within the requirements

of the law. And the state supplemental rebates do not ever affect best price.

Okay. Now everybody should stay calm when looking at this. Basically, I was just trying to describe money flows in the Medicaid program, because it's not intuitive -- you know, there's no quiz later -- just to show you a couple of things.

So this over here, again, in general, without a ton of detail, but the average manufacturer price that is calculated for that 23.1 percent rebate sort of comes from this segment of the marketplace. AMP is trying to get at, really, what the retail pharmacy tends to pay for the products.

Over here you have the sort of rebate channel, and that's going to the payer, and the point here is that the rebates are like completely distinct from what the retail pharmacy is getting paid and what the retail pharmacy has paid to acquire the drugs. So it's sort of a whole separate stream of money flows.

And then the third section here is Medicaid has to is -- is, obviously, obligated to reimburse the retail pharmacy for its acquisition costs, and they do that either

through the MCOs, the managed care programs, or directly in a fee-for-service program. And the point here is to think that most payers, whether it's Medicaid or someone else, are really trying to pay the retail pharmacy the cost it acquired -- the cost at which the pharmacy acquired the drug, rather than, they're really trying to squeeze the margin on the retail pharmacy, frankly. And then they also give them a professional dispensing fee to compensate.

So, again, there's sort of really separate sets of transactions going on and they're not necessarily highly related.

Cost-containment tools, I'm sure almost everybody here is pretty familiar with most of these -- how these things work. But in the commercial sector, obviously, gathering market share, aggregating covered lives. The more covered lives you have, the more interest and attention you'll get from a pharmaceutical manufacturer, in terms of striking discount and rebate agreements. And I would argue sort of that whole phenomenon, if you will, is sort of what has given rise to PBMs, and the strength of PBMs, and the consolidation of PBMs in the market.

Medicaid, not so much, I think, for supplemental

rebates. I don't know this for a fact but I would intuit that New York probably has better market leverage than, say, Alabama or Utah, just because of covered lives in the Medicaid program. But states do aggregate their Medicaid pools and approach manufacturers as one body, to compensate for that.

So tiers and cost-sharing, commercial sector, obviously, uses those, as we all know personally, even, to great effect. We're seeing a lot of innovation, if you will, benefit design innovation in this sector, on the commercial side, where I'd say like 10 years ago, or more, most of the formulary tiers, when they started to appear, were just three tiers, sort of a generic, a brand, and then a specialty tier. And a consumer's point-of-service obligation -- payment obligation increased as those tiers increased.

And now sort of given all sorts of things that have happened in the marketplace, including a lot of new generic drugs, a lot of branded, therapeutic competition in certain therapeutic classes, like oncolytics or hepatitis C, for instance, as an example, we're seeing six-tier formularies -- preferred generics, non-preferred generics,

preferred brands, non-preferred brands, preferred specialty, and non-preferred specialty. And again, that's because of a lot of the innovation that the manufacturers are producing in therapeutic classes as well as the transition to generics that's allowing that.

Medicaid has pretty limited ability to do that. Medicaid copays in the drug space are limited to $4 for preferred products, $8 for non-preferred products, for people under 150 percent of poverty. So basically it's two tiers. States have the option of doing 20 percent coinsurance for non-preferred brands, for people over 150 percent of poverty.

I've done a little bit of eyeballing of some of the data out there, about how states are structuring their cost-sharing and their tiers -- well, they have two tiers -- their cost-sharing, and most states are not even using the existing authority that they have around copayments. Most states, their copayments for sort of all of their populations are under $4. So I'd say it's -- that's why I've termed it limited ability and limited use at the same time.

So restricted formularies. Commercial markets

are using those more and more. And a restricted formulary is, in my view, anyway, for the purposes of our discussion today, is when a prescription drug plan will not cover a drug. Like if you want Advair, you can't get Advair. It is not covered. Its therapeutic alternates may be covered but Advair is not. Or we're seeing it with the hepatitis C products. The manufacturer will get a preferred position on a formulary and then the payer will not cover any of the other hepatitis C products. I mean, this can really only happen when there's real good therapeutic alternates on the market.

Medicaid can do this, to some extent, through preferred drug lists. I think if you talk to Medicaid directors they feel like this is a very weak tool, because law requires them to cover every drug for which there is a manufacturer rebate agreement. I think if you talk to manufacturers they will find that they feel like this actually is a fairly effective thing. So the truth is probably somewhere in between.

Utilization management, I think Medicaid and commercial markets are pretty much on par with stepped therapy, quantity limits, and prior authorization. And

then performance-based contracting is sort of a new tool on the scene, and it's picking up speed, I think, in the commercial market, and I think it's a huge open question for a bunch of statutory, regulatory, and administrative capability reasons in Medicaid. But performance-based contracting is where your manufacturer discount to a payer is based on the performance of the drug.

So there's -- we can talk more about it, but, in general, these performance-based contracts are really only useful and accessible at this point in time with products that have clear endpoints. They prevent a hospital admission, or, you know, they get you to a certain level of HbA1c. Very clear endpoints. Things that are sort of fuzzy, a lot of chronic condition medications aren't necessarily suitable for this.

So -- oh, I am moving along good. Okay. So here are some options that we were thinking about that you may want to consider, or you may not want to consider any of these, or something else. But some of the things that we were thinking about, give where Medicaid statute and law is and the effectiveness of the Medicaid rebates, I really do consider the Medicaid rebate structure to be sort of the

workhorse of Medicaid prescription drug cost-containment, because it's incredibly effective. Chris' work over time has shown that it's consistently returning about 47 percent back to the program of drug spend on a fairly consistent basis. Regardless, this changes in the composition of the drugs that are being utilized in the program.

So here are some things we may want to talk about or explore further, but one of them would be encouraging Medicaid value-based contracting. Again, there's more questions than anything in this space, and if you thought that this was a valuable thing to proceed with, I think we would need to investigate the level of state interest. We don't know the level of state interest per se in this. And then what we think or what states think the savings potential is of doing all of this work around performance-based contracting relative to what the workhorse rebates already produce for the program. But it is a place that further work would be needed.

And then possibly looking at ways of discouraging large price increases in the program. Medicaid officials will tell sort of the worst problem for them is these drugs may have a high degree of value -- you know, medical,

clinical, and, you know, phenomenal innovation -- but they're just not affordable, and particularly when price increases or new launches occur in the middle of the year, when their budgets are already set, and they're very expensive products. So we may want to look at ways of discouraging large price increases in the Medicaid program, maybe looking at the CPI penalty and working with that and some way calibrating it based on the size of the increase.

And then there's also uncapping the rebate. A thing I didn't touch on earlier is that statute caps a manufacturer's liability, for their rebate liability, to nothing more than 100 percent of the AMP, and that was put in place -- I think it was the Part D legislation. It was put in place because the CPI penalty, over time, over a product's lifetime prior to becoming a generic, the business model is to take small, typically historically small price increases every year, and so the cumulative effect of those price increases and the CPI penalty applied to it led, in some cases, for manufacturers actually paying 108, 110, 112 percent of the AMP. And so it was capped at 100 percent, and we may want to investigate what it would mean for the program to uncap that, to have manufacturers

pay more than 100 percent, as a policy matter of addressing price increases, these very large price increases that people are aware of now.

I would also say that we should think about -- if we're going to be discouraging price increases, we should think about incentivizing lower launch prices, you know, for the old balloon analogy. Right? If you were to squeeze out manufacturer ability to use their business model and take price -- increase price every year, presumably -- they're smart people -- they would look to increase their launch prices. If you were only going to get at their launch prices they would lower their launch prices and use their ability to increase prices annually.

So I think we -- if we're going to look at this space, we probably need to look at both things together, and one of the ideas we've come up with is thinking about reducing the AMP rebate, something lower than 23.1 percent for launch prices that come in below some thresholds, relative to other products that treat the same diseases.

And then the last one we came up with, for consideration, is thinking about requiring Medicare to share in the costs of drugs that benefit Medicare in the

future, that Medicaid has paid for. Clearly, this wouldn't be like every drug. It would be something like hepatitis C, for instance, where you look at the prevalence and the population indicated for the drug, you know, which is mostly baby boomers, people aging into the Medicare program, and it's a cure, and it's very expensive.

That might be something, or vaccines, if the Pneumovax vaccine is indicated for the population. It's a one-time product, but it's a costly vaccine and it would benefit Medicare as people age into Medicare. Or the shingles vaccine is something else that comes to mind. It's indicated for people near Medicare age, you know, and properly they should get it at the age at which they're indicated for it, but the savings really would accrue to Medicare.

And there is precedent -- and then I'll wrap it up -- but there is precedent for this in terms of the -- on the flip side, which is the Medicare Part D clawback, which is when -- Chuck, you look like you know this -- so when the Medicare Part D program was created, the drug coverage for the dually eligible population moved from Medicaid to Medicare and resulted in substantial savings for the

Medicaid program. That didn't go unnoticed, and part of the law was to call back the savings, the estimated savings from states, for like every year, in perpetuity, and they're still doing it. But it has to do with, because Medicare was saving Medicaid money, and so there is a precedent out there for thinking of something about Medicare sharing and Medicaid drug costs.

So that's it. So next steps, your feedback on these options, or any other options that you have, if you think anything merits further investigation, and then any additional analysis that you think that would be helpful in this space.

CHAIR ROSENBAUM: So let's start with Peter, then Toby and Sheldon.

COMMISSIONER SZILAGYI: That was really an excellent presentation. Just kind of a flippant comment and then a question.

The flippant comment, the pediatrician in me, that last -- requiring Medicare to share in the cost, the pediatrician in me thinks, Wow, Medicare should subsidized all of pediatric care because so much of pediatrics, the savings is in the adult, is in the adult world. This is

the life course -- you know, that's not even an hypothesis. This is really the life course concept. And I wasn't completely flippant about that.

MS. HORVATH: I could see that.

COMMISSIONER SZILAGYI: But the question -- and Chris may have already presented this. Are there large state variations in what Medicaid pays for drug costs?

MS. HORVATH: So, Chris, correct me if I'm wrong, we don't -- we just have sort of the aggregate spend on a state-by-state basis. We were actually talking about breaking it down into per capita and seeing if there were big differences that popped up.

COMMISSIONER SZILAGYI: Because if there are large variations -- I don't know if that data is available -- you know, for the same drug, you can learn a lot by variations. You know, what if somebody -- what if one state -- what have they figured out that other states have not?

MS. HORVATH: We've been talking about doing sort of a per capita drilling down and seeing if there was -- and then going back and looking at their drug management, their formularies, and their utilization management tools

to see if there was anything exceptional. But there's a big time lag.

MR. PARK: Yeah, and CMS publishes a quarterly chart of what states' reimbursement formulas are to the pharmacies, and generally they're fairly similar. You know, there are some differences, but I would say on average there's not that much variation in terms of what they pay the pharmacy. And with the new drug role, all of them will have to go to an average acquisition cost-based methodology. So that could be different in every state as to what pharmacy mix they have. But a lot of the states will use a national survey. You know, that's what we've seen so far; states are adopting a national survey.

MS. HORVATH: Right. They're all driving toward paying acquisition cost or estimated acquisition cost. But I think the real variety that we would find there is looking at per capita spend, and then, you know, looking for big differences, and then going back and looking at things that are not claims but are formulary management.

COMMISSIONER DOUGLAS: Great job of a very complicated area in Medicaid, so really good overview. I have a couple questions and also comments, so on PBMs, on

the MCO side, in your diagram or just even in -- where do you see that fitting in? Because that plays, you know -- from the MCO perspective now, that's a big way of value-based --

MS. HORVATH: Yes.

COMMISSIONER DOUGLAS: And I don't even know if you've defined that in the value-based contracting or is that separate?

MS. HORVATH: So just to get to where it is on the chart, let's just start with that.

COMMISSIONER DOUGLAS: Okay.

MS. HORVATH: Like we thought about putting it on, and then everything just started to get kind of wild and woolly, and so I would say that the MCO sort of stands in, you know, just in terms of what's happening with the private sector. We left it off specifically --

COMMISSIONER DOUGLAS: But it's not -- so it's fair to say they're not -- the estimated acquisition cost would not be -- you know, there's --

MS. HORVATH: No, but in terms of the rebates going.

COMMISSIONER DOUGLAS: Yes. But on the right

side, it wouldn't be -- that's part of it's a value-based -- in certain ways it is a value-based contracting approach, right?

MS. HORVATH: It can be. You know, they're definitely getting into that space with manufacturers on particular drugs. Value-based contracting is usually drug by drug specific in terms of how it's typically used.

COMMISSIONER DOUGLAS: Okay.

MS. HORVATH: The term.

COMMISSIONER DOUGLAS: To me, it's select -- there's some level of -- it's driving down the costs.

MS. HORVATH: Totally.

COMMISSIONER DOUGLAS: Which is important kind of in those four rebate types, it's kind of its own -- it's almost another type. And then you're right on the value-based of it, now I understand what you're saying. You're talking about like, for example, blood factor, of coming up with specific goals and measurements --

MS. HORVATH: Right.

COMMISSIONER DOUGLAS: -- and performance on, you know, both on cost and what you expect on the outcome.

MS. HORVATH: Or like actually what I was really

thinking of was like Entresto, so it's a Novartis heart drug, and it has gotten really good clinical results. It has a whole bunch of clinical profiles and effects, but the bottom line is it really does prevent inpatient days. It really keeps people out of the hospital. And, you know, they've done a bunch of work to sort of demonstrate what the effective rate of non-hospitalization is, and so they're contracting with payers, and they're saying, like, look, if your people wind up in the hospital on our drug, it's on us, like "We owe you" kind of thing. So it's a very clear endpoint.

I'm trying to think -- I don't know that anybody's doing performance-based contracting with the hep C drugs, but an example would be in that case the person is not cured. You know, they're just not cured. And so it's a performance-based contract. The payer wouldn't pay or the manufacturer would rebate the full price, or something like that. But that's what I'm talking about.

COMMISSIONER DOUGLAS: Got it.

MS. HORVATH: As opposed to what I think you're referencing, is things that Express Scripts does. They negotiate with a manufacturer. They'll sit a whole bunch

of manufacturers down with COPD drugs like Advair, that whole sort of class of drugs.

COMMISSIONER DOUGLAS: And they'll work with the pharmacies to really drive, you know, that on both sides.

MS. HORVATH: Right. And they're determining the value, like Express Scripts is determining sort of the clinical value and then like the best agreement they can get with a manufacturer, and then everybody else is off.

VICE CHAIR GOLD: But my sense -- and correct me if I'm wrong -- on that point, I mean, the managed care organizations use the MCOs, the PBMs to do that. But I have a sense that in Medicaid, there's limits, partly -- what Medicaid's doing is using its market power to get these rebates and to do other things. It has a little bit of use of formulary or other things, but it's not set up --

COMMISSIONER DOUGLAS: Well, maybe that's where I'm --

VICE CHAIR GOLD: It's a different strategy than the private sector has traditionally used. It's starting to use them. So in a managed care organization, for example, that participates in Medicaid, what is -- they're pretty much also following the Medicaid rules, or how much

-- they don't have a lot of flexibility to do cost sharing.

COMMISSIONER DOUGLAS: No, that's --

VICE CHAIR GOLD: I'm not saying they should, but that's --

COMMISSIONER DOUGLAS: Well, wait a sec. On the PBM side, so they are -- you know, managed -- again, I work for a Medicaid managed care plan. They're using PBMs, so, no, it's the same as the commercial, and I think there's -- this gets to kind of the intersection -- you know, I was going to say, on the options, I don't have strong feeling on most of them, although I want to talk about the Medicare one. But I do think there needs to be some exploration of as we've moved more and more to managed care, it impacts the state supplemental rebate intersection --

MS. HORVATH: Yes.

COMMISSIONER DOUGLAS: Because, you know, the way states have been driving state supplemental rebate is a PDL. Well, now you have managed care plans that are contracting with PBMs that have their PDL. You can't -- you have a tension there between those two, which means a reduction in state supplemental rebates. But it's some states -- and when I was in California -- look at one

uniform PDL. Well, managed care plans don't like that because --

MS. HORVATH: Right.

COMMISSIONER DOUGLAS: And it has an intersection on the cost that they're going to get.

MS. HORVATH: It does.

COMMISSIONER DOUGLAS: So I don't know what -- you know, which is better, having a uniform PDL from just a total spend perspective, or letting the plans have their own PBMs. That is some type of exploration that needs to be done, and I'd like Chuck's thoughts on that, too.

On the Medicare piece, I'm a little wary on that because I think it gets to a bigger discussion, because I think you can make the same argument, which we always like to have on the duals and other areas of, you know, different spends. I think it's a little different than the clawback, which I think was more --

MS. HORVATH: It is.

COMMISSIONER DOUGLAS: -- a question of we're taking back a piece of the program and giving -- now that Medicare is taking this over, then you're going to pay for it. And some states didn't actually feel like they saved

money. That's not -- but I would put that in a bucket, which obviously I would love to explore around ways of Medicaid and Medicare interacting, but not on the pharmacy discussion.

MS. HORVATH: Okay.

COMMISSIONER DOUGLAS: So I'll be quiet there. Thank you.

COMMISSIONER RETCHIN: Well, I think that was not only a great review but sort of, I think, also reveals the depth of your expertise, and I look forward to further discussions. I must say that just -- so most of the things that you discussed, Jane, are really about pharma and pricing. Am I wrong?

MS. HORVATH: No, you're -- that's right.

COMMISSIONER RETCHIN: Yeah. So if we took the ten highest-priced drugs for Medicaid, highest-priced, then looked in the next column, the ten highest-cost drugs, there's some linkage, but not a lot, I would think.

MS. HORVATH: So highest priced and highest spend.

COMMISSIONER RETCHIN: That's what I meant, cost and spend.

MS. HORVATH: Right.

COMMISSIONER RETCHIN: Right, which I guess we've sort of left off here, although you could get to --

MS. HORVATH: We haven't done it.

COMMISSIONER RETCHIN: -- in performance-based contracting, which is a really fascinating concept, which leads me to the next question, but you were going to respond.

MS. HORVATH: I was going to say I agree, and we haven't -- Chris and I have talked about starting that work sort of pending the discussion here and stuff to look at the price and the spend and the --

COMMISSIONER RETCHIN: It gets into a very peculiar -- or, I guess, discussion area that's peculiar to Medicaid where you can talk about beneficiaries that have special needs compared to the Medicare or commercial populations, but just to get to that. And also in the performance-based contracting, I was sitting here thinking about some of the outcomes that you'd be looking at, which are interesting. Some could take years. But, in particular, even though maybe it's not as applicable to Medicaid as I might think, but the oncologic drugs, not

where there's performance-based, okay, you hit it, but, rather, when you're looking at average return of three or six months of life, which really brings out an incredible discussion in terms of heroic efforts, very expensive. I'm not sure how you get to that.

Then, lastly, the Medicare discussion that you brought up was really interesting. That's an argument -- I would love to be in a room for that. And I know --

[Laughter.]

COMMISSIONER RETCHIN: And I know -- it's not that I have a wasted life watching too many movies, but it does bring to mind "Minority Report."

[Laughter.]

COMMISSIONER RETCHIN: You know, somebody zooming into a room, we prevented a disease before it happened. Anyway, I don't want to keep going on. I'm going to start reading books.

[Laughter.]

CHAIR ROSENBAUM: [off microphone] your phone, you know.

COMMISSIONER GORTON: So two thoughts. One, I think what you described about pursuing another level of

analysis in terms of PMPM spend and sort of drug classes. I think that could show some interesting variation and is worth doing.

I do think you'll want to compare fee-for-service versus managed care because I think there are some places where the plans are probably doing a pretty good job. I think there are some places where the plans are not doing a pretty good job, and some of that comes back to some of these constraints that you talked about, which, when they cascade down to the plans, the plans in some cases have the worst of all worlds. They have to live within the Medicaid rules, and to the extent, for example, a state says the minute that a manufacturer signs the rebate agreement, it goes on the formulary. In the commercial world, there's usually -- in the explanation of coverage, it says we have up to six months to decide whether or not to add an agent.

MS. HORVATH: Yeah.

COMMISSIONER GORTON: A lot of that is just around being able to underwrite the risk.

MS. HORVATH: Right.

COMMISSIONER GORTON: You know, when Sovaldi came on and the nominal rebate was signed, all of a sudden we

had a tens of million dollar -- at a state level, we had hundreds of millions of dollars of liability. And so, you know, it's worth -- again, since we have this bifurcated system, it's an opportunity to explore that. And Toby and I had that AHIPs meeting in town this week, so Toby and I had a chance to meet with some of our colleagues in the Medicaid plans. And what we explored with them, both AHIP staff and with our plan colleagues, is, you know, you don't have to necessarily wait until CMS can produce you a data set. We do have ways to make data available that could give you a window into what's going on in the MCO world as long as we have proper respect for confidential business arrangements. So I think we're at a place where AHIP would be willing to sort of broker some of these conversations if you want to do that.

The second thought, I was really intrigued about what you said about incentivized lower launch prices. The Europeans have used reference pricing for new drugs for a long time, and it seems like with some success. And while price controls are the third rail of American health care, it does seem like reference pricing might be at least a path to explore, because you have this phenomenon of the

"me, too" drugs, right? Somebody comes out, they launch a drug, they put a price on it. The next one comes out, it's a little more expensive. By the time you get to the fifth or the sixth one, you now have this huge class. And what's interesting about it is the prices don't then go down. The prices all rise to the highest level that anybody was able to get from the market.

And so it seems to me that -- and irrespective of the fact that there's a 30-year-old generic that does as good a job. So it seems to me that what the Europeans have adopted, which is to say, okay, we'll put your drug on, but, by the way, we can buy a solution for this problem for pennies a pill, yours is not materially different, so we're going to pay for yours what we pay for that one, I think that would be worth sort of exploring how it works over there and is there any way that it could be adapted to the American context.

MS. HORVATH: So can I just comment on that real quick?

COMMISSIONER GORTON: Please.

MS. HORVATH: So the reference pricing thing is really interesting. How it works in Europe, reference

pricing is often a country picking the lowest price among a bunch of countries that they use for their sort of market basket on a drug. And, you know, I think it's fair to say that the manufacturers try very hard to keep the U.S. market out of that market basket, which is why you have such confidentiality around these rebate agreements, because otherwise it will get all swept up into the European reference pricing. I mean, there's a lot of concerns there that, you know, we should just explore as well. I just wanted to flag that.

COMMISSIONER COHEN: Great presentation and a really important subject. I just wanted to ask, in terms of your questions about options for possible further exploration if you think there is a valuable body of work in looking at -- I'm going to lump a whole bunch of things together that probably don't belong together because that's like where my state of knowledge is, things like effectiveness, like medication management, you know, step therapy or fail-first -- UM policies I guess these sort of are, physician, the state of like whether physician override, like how many states does that exist and how much does that, you know, drive or change spending. And then I

know both in the Medicare drug debates and I know in New York at least there is still sort of substantial discussion about special categories of drugs where there's, you know, sort of much freer and broader access and just sort of getting some sense of the variation on those things and how much they relate to spending. They may also relate somehow -- we'll probably never know with the state of our data, like better quality or better outcomes, but just to sort of get a sense of what the lay of the land is on those policies and whether those are best practices, best combinations, is another area for us to explore in addition to pricing.

VICE CHAIR GOLD: Like others said, I think this is great, and I think that it's going to serve us well to have more work in this area, and you actually bring an awful lot to the Commission. I just had a couple of quick comments.

I think that one of the things that's important -- and you probably will have a sense of this maybe much more than us -- is to focus on things that are actionable, where you think it's both actionable and it's important so it can make a difference. So looking at the highest-cost

drugs or the new entrant drugs or the most-volume drugs or something that makes it important, you know, I think is -- and also where there's not something that you sort of know -- everyone's banging their head against this wall for 17 million years. We're never going to get anywhere. So, you know, there are some low-hanging fruit and where can we help with that?

The other thing is just a caution as a researcher on looking at per capita spending and caps and comparing managed care and others. The issue is population mix, and both across states and between managed care and other things, there's so many differences in the people and the difference programs that interpreting what you're finding becomes difficult. So I think it's better study if you can limit it to people who have X or people who are in the same eligibility category X, but to really think about it. Otherwise, it's sort of apples and oranges and hard to interpret.

MS. HORVATH: Well, if we're looking by drug class, I think we're sort of, by definition, winnowing down the variability in the population, like people with hepatitis kind of thing.

VICE CHAIR GOLD: Yeah, and there's all ways to do it. I was picking upon Chuck's comment, and I just thought that we probably should be careful because that's where we run into issues of, well, what's causing this. And we don't want to spend a whole bunch of time trying to figure out something that isn't actionable at the end, anyway, because it really was based on a selection effect or something.

CHAIR ROSENBAUM: Penny.

COMMISSIONER THOMPSON: Thanks, Jane. Terrific.

I wasn't sure if this was really embedded in the MCAP rebate limit concept or not, but it's just the idea of looking at whether we need to revisit the basic rebate bargain, the basic rebate bargain being you sign the rebate agreement, you're covered; and are there some exceptions or some circumstances in which that bargain ought to be reevaluated.

CHAIR ROSENBAUM: Right. I should just note that was the issue I was going to raise, which is whether the fundamental premise of the original structure is something that now that we've made so much -- we know so much more than we may have known when the rebate system was first set

up, we want to raise, and whether there's specific circumstances in which we might modify.

I have Chuck and then Stacey.

COMMISSIONER MILLIGAN: I was going to make exactly that point, Penny, and I want to elaborate on it just a little bit.

The Drug Rebate Act -- I think it was 1991, and then it was again over in '93, I think -- the bargain was the manufacturers will give the rebates. In exchange, you have to put in your formulary all of the FDA-approved drugs. I think revisiting that for a couple of reasons -- the first is Medicaid's enrollment levels, Medicaid's scale is so much bigger now that I think that Medicaid's bargaining power is in a fundamentally different place than it was in the early '90s about getting rebates in the first place.

I think the second other dynamic that's changed a lot in the interim is that there's so much more use of managed care, and the managed care organizations -- and I'll use United as an example in a second -- just have a lot more leverage across States, across business lines, that I question whether those rebates are achievable. I

think those rebates are achievable, by and large, without having to make the bargain of listing all drugs.

Having said that, we want to make sure the beneficiaries get the drugs they need, and so there could be some reviews about making sure that there's adequate coverage of therapeutic classes and so on. But I do think that revisiting the Drug Rebate Act is appropriate.

A couple of other comments. One is I wanted just to pick up on -- and Toby invited me to speak to this. I think a lot of States look at pharmacy and should there be a common PDL and so on because it makes prescribers' lives easier. It makes members and advocates and a lot of lives easier, and States -- and I'll use New Mexico as an example -- they think if they combine the scale of the MCOs they've got that that will get leverage pricing-wise, but it pales in comparison to what United can get nationally and internationally and employer insurance.

I just think that there's a -- how we kind of tackle who has what scale to bring, volume to bear on price, is a more complicated thing that it looks at first blush. I'll just leave it there.

The one other comment, I guess -- so I like

everything on your list in terms of options for further exploration. I do think that the point about incentivizing lower launch prices, I think that I would take the frame out a little bit and just investigating pricing, period.

Kit mentioned reference pricing. We've heard lots of discussions in other contexts about 340B and who has access to it and under what circumstances, which is a cheaper price than Medicaid gets otherwise, but bigger even than that, I think we should not narrow our frame so much that we're taking Medicaid out of the broader debate that's happening now in Congress and nationally around the fairness of pricing decisions that are made.

And I'm not trying to get to the price-control third rail issue, but I want to make sure that Medicaid isn't isolated from the broader debate about affordability of drug pricing and the transparency and sensibility of manufacturer decisions around pricing.

So that's all I have. Thank you.

CHAIR ROSENBAUM: Stacey.

COMMISSIONER LAMPKIN: Thanks. I'll try to be quick.

I don't disagree with a lot of this, the broader

picture, the item that Penny brought up, but I would like to understand a little bit more about the middle three bullets that you have on your issues. I think all three of those, at least for us to understand them better and understand how they affect things, even if we end up using that information in a broader context, it just would be useful, I think.

And then just a quick comment related to Toby's and Chuck's on managed care and rebates. I've had the opportunity to sit on the payer's side of that decision-making and calculation. I've actually seen results for three States, I think, looking at that picture, and it's interesting because there's way more to that decision than just how the money works out. But how the money works out is important, and it's not just the supplemental payments that you have to worry about. You also have to worry about just the basic Medicaid rebate and how the mix of drugs affects that. And, yes, you've got a higher capitation rate, then you move to a uniform formulary, but you get the money back.

So there's a lot of complicated net-net there that involves more than just the supplemental rebates, and

the one that I've seen, there's not -- it's not going to come out on one side of the equation consistently for every State. I mean, there are nuances that affect the results.

CHAIR ROSENBAUM: Marsha.

VICE CHAIR GOLD: Just a quick thing in terms of -- and I didn't know Stacey knew anything about this. I mean, it's important to look at the composition of Medicaid managed care plans. There's a bunch of different sponsors, and some of them have more clout with drug pricing than others. So you have United and Aetna in there, but there's a lot of mom-and-pops, and there's a lot of Medicaid-only plans. So, if you're looking at what the clout is -- and I don't know if you've seen that, Stacey, in the States you've worked in. I've always kind of assumed that the Medicaid rules usually work to the advantage of the program, though I agree as you move to managed care, there's an issue of how the best way is to manage the care of the people.

CHAIR ROSENBAUM: Just one additional point to add. I think this has been a great discussion. It was a great piece of work, and you can see that the Commission is sort of eager to go here.

The one thing I would raise as a slight cautionary note, while I agree with everything that's been said and particularly Chuck's admonition that we make sure that Medicaid is part of the broader debate that's happening around drugs, my one cautionary note is that Medicaid plays quite a unique role in society.

I was thinking before, well, we backed out, of course, Medicare beneficiaries for drugs, but for that part of the population, which this Commission has visited in the past in some detail, probably more than almost anybody -- that is, children and adults typically on Medicaid only with profound disabilities, where Medicaid really is all there is, and it's just totally unlike any other payer -- I think we do want to just keep in the back of our mind as we're looking for normative changes that would allow greater management, greater population management, and greater cost efficiencies, that Medicaid is a program that also is actually constructed not to always have to deal in the norms that we find in commercial insurance markets or even in Medicare, where normative design is a feature of the program.

Even as we try and take advantage of some of the

normative developments that have happened over the 30 years, almost, that we've been using this structure, I do think that Medicaid remains a unique source of funding for a group of people who need long-term services and supports, where we're going next.

We have experimented now in certain markets, with exceptions processes, with other processes that allow singular management of conditions, and I think it's just something we want to keep on the table.

Any other comment?

[No response.]

CHAIR ROSENBAUM: All right. Well, why don't we move, then, immediately into our next discussion.

Thank you, Jane.

We're going to turn to Money Follows the Person Demonstration Program, progress and questions. We will finish with opioids.

MONEY FOLLOWS THE PERSON DEMONSTRATION PROGRAM: PROGRESS TO DATE AND QUESTIONS FOR THE FUTURE

* MS. VARDAMAN: Good afternoon, Commissioners. I will be providing an overview today of the Money Follows the Person Demonstration, some of what we know about the

results, and setting up some policy questions.

I will start off with some background on the demonstration and the results, and then I'll go into the timeline for the demonstrations and what we know about state sustainability plans, and then end with some policy questions and next steps as well as soliciting your feedback on where the Commission might be interested in going as we prepare for the final evaluation and report to Congress on the Money Follows the Person Demonstration and also think about the broader role of Medicaid and housing.

So Money Follows the Person was first authorized in the Deficit Reduction Act of 2005 and extended by the Affordable Care Act. It provided funding states to assist them in improving access to HCBS, and currently, 43 states and the District of Columbia are participating. I'll go over a little more detail later about how States are winding down in the program. Although the final awards were made in fiscal year 2016, states do have a few more years to spend the money that they were granted.

So the main part of the Money Follows the Person Demonstration is the transition support, and it assists beneficiaries who have been in an institution for at least

90 days and are returning to the community. So this could be a home or apartment or certain qualified residential care settings.

Beneficiaries who have been in an institution for that time or longer are able to receive home- and community-based services that are beyond what they would have received if they had not been institutionalized, and so this helps them get set up in a community residence.

For example, they may be able to get additional personal care services, payment of security deposits, and other things that wouldn't be a part of the State's existing home- and community-based services programs.

Depending on what services States have decided to provide, they can earn an enhanced match, which varies by State, and that enhanced match is used to fund rebalancing efforts that go broader than those who have been institutionalized. These are things that are aimed to help States rebalance and increase home- and community-based service utilization, reducing reliance on institutional services, such as reducing waiting lists for HCBS waivers, providing housing supports to all beneficiary who are in need of HCBS and other supports.

In addition, the Money Follows the Person Demonstration provides reimbursement for different administrative costs associated with the demonstration as well as technical assistance to States to work through challenges.

Each year, the evaluation contractor has put out an evaluation report as well as some progress reports updating on progress that States have had in transitioning beneficiaries back to the community. Based on the most recent progress report, as of December 2015, States had transitioned over 63,000 beneficiaries back to the community through the MFP program.

The number of transitions varied widely by state, and the most recent evaluation report using 2010 data, which was the most recently available at the time, the conclusion was that it was unclear whether the beneficiaries would have transitioned if the MFP program did not exist. And so we're hoping that in the next evaluation report, which is expected soon, we'll have more recent data and be able to say a little bit more about what the impact of MFP has been on states' ability to transition beneficiaries to the community.

States varied in their achievement of transition goals based on the most recent progress reports, and states have reported that the biggest limiting factor in being able to transition beneficiaries from institutions to the community is the lack of affordable and accessible housing.

In addition, states have used the enhanced match that they've earned for transitioning beneficiaries and providing them services, most frequently to expand or enhance their waiver programs, and over the course of the demonstration, spending on HCBS has increased. The states that participated set spending targets, and overall, states have, on average, achieved those targets. However, for 2015, 20 states were below their spending targets for that year.

In terms of the demonstrations wind-down, the ACA funded MFP awards through 2016. All states that transitioned beneficiaries to 2015 received approved budgets for 2016 to 2020. States are planning to end transitioning beneficiaries at varying time points. Some will end in 2017, some in 2018, so this is when they enroll, sort of beneficiaries to transition, and then provide them services over the following year. And so they

will have to claim all of the funds or all of the costs involved in transitioning those beneficiaries by 2020.

And as part of the final award, States had to submit sustainability plans that describe how they plan to continue transitioning beneficiaries once the demonstration came to an answer, which services that they would sustain and which services they would decide to let go.

So we have had a chance to review a few of those plans and talked to one state so far. Based on what we've reviewed, states generally say that they do intend to continue transitioning beneficiaries, and how they were to do so just varies by state. Some identified services that they would not continue, either through focus groups or looking at those services that weren't well utilized.

In addition, generally, states, if they're looking to continue certain services, have to be able to incorporate those into their existing programs, and so states lay out in these sustainability plans which services they plan to continue, what their plans are to weave them into their existing programs.

However, this one state we talked to talked about state budget pressures as being a limiting factor in how

much they will be able to continue, and so they have to be able to justify continuing those services. And with budget pressures, they were uncertain whether their sustainability plan as written would be what they end up implementing. So, if they're not able to include all these services into their waiver programs, then certain services could be restricted to beneficiaries and certain waivers, so a service may not be available to all HCBS beneficiaries.

In terms of policy questions, the first is thinking about whether or not the demonstration has been successful in achieving its intended goals. Again, we hope that the upcoming evaluation will provide some updated information on whether or not states were able to transition beneficiaries who would not have transitioned in its absence.

Second, given that there are at least some states that have concerns about their ability to continue certain transition services, once the demonstration ends, the Commission may want to think about whether or not a permanent enhanced funding stream is needed for certain services based on how those can be justified.

And then, finally, again, the Money Follows the

Person Demonstration identified housing as a major limiting factor in transitioning beneficiaries, and that's an issue that goes beyond the demonstration. And there's been a lot of activity at CMS around housing, and so another question the Commission might want to consider is what the appropriate role of Medicaid is in supporting housing needs of HCBS users, both those transitioning from institutions and also those who are already in the community and preventing them from being institutionalized?

So, in terms of next steps, we know that the Secretary has the report to Congress. That's currently under review, and so part of this session is to set up this issue for you all because I will be coming back to you once that report is ready, and you have an opportunity to provide comments at that time. So it would be helpful to know if there's some information that you would like staff to be working on in anticipation of that report so that when it's time to comment, we will have something to contribute.

In addition, we're also in a learning mode on trying to understand the various initiatives around housing at CMS. If there's any information or future work that you

would like to see in that area, we would welcome your input at this time.

CHAIR ROSENBAUM: Thank you.

So comments? Marsha.

VICE CHAIR GOLD: Yeah. You may know this already, but if not, it would be useful to find out. I'm wondering. You say has the demonstration been successful in achieving its intended goals, and I guess the question is what metrics are going to be able to be reported in the report, because it strikes me that there's several different things that affect how we think about it. Did it save money for the people who transitioned? What percentage of people that they tried to transition was successful? What characteristics define who might or might not be most effectively transitioned?

Especially, I'm very interested in whether they're going to have any information from surveys or focus groups of the people transitioned or their families or their caregivers as to what difference it made, and also, if this is a group that was institutionalized, I would be interested in how long they were institutionalized and whether it was easier to do some than others and whether

the costs vary, because one of the questions is, when you rebalance, should you avoid getting people going in to begin with, so that they're out there. They don't go in, so you can keep them out, but then there's the concern that that's the woodwork effect, and everyone will come out.

I don't know which of those questions the evaluation was asked to address and what data it will have, but it would be useful to think about the kinds of findings it will have because those have implications not only for extending it or not, but also how to shape it so that it's most effective and also so that it most meets the needs of beneficiaries.

CHAIR ROSENBAUM: Brian.

COMMISSIONER BURWELL: So I think Congress specifically asked us to give them recommendations on any extension of this demonstration, and I am interpreting that request in the context of not are we going to extend MFP as it currently stands, but how should we look at continued investments and the development of home- and community-based services.

The MFP demonstration has been a very challenging and problematic demonstration from many points of view.

It's been very difficult for states to develop the infrastructure to achieve its goals. In many states' cases, it has not achieved its goals, and as was said in the report, the evaluation did not find that people who were transitioned under the demonstration would not have been transitioned in the absence of the demonstration.

VICE CHAIR GOLD: Interim findings.

COMMISSIONER BURWELL: In the interim findings.

The final report is currently in and being rewritten by CMS.

I think our thinking about a recommendation should be much broader than just the MFP demonstration itself. In fact, my conversations with people in the disability community have been fairly resigned, saying that the evaluation is basically killing any prospect of a continuation of MFP in its current form because of the negative findings of the evaluation.

CHAIR ROSENBAUM: That it didn't achieve an increase in deinstitutionalization.

COMMISSIONER BURWELL: But I think that there is a strong interest in Congress to continue support of the expansion of home- and community-based services, and so I

think we should look at it from that point of view.

I do think that there's a basic accounting question that I would like answered. You will note that there was $4 billion expended in the demonstration, and then later on, you find that the enhanced funding for people who have been transitioned totaled something like $220 million. There's $3.8 billion that's still not accounted for. I would like to see a fairly detailed accounting of where the $4 billion in MFP funding actually went to over the course of the demonstration, and I think that would be elucidating.

I think it would be good to have a presentation by either Mathematica or CMS at a future meeting regarding the results of the evaluation. I think that would be a good thing for us to participate in before we make any recommendations.

CHAIR ROSENBAUM: So I have one question maybe for -- well, either for Kristal or for you, and that is this sort of -- I guess for somebody who hasn't thought a lot about this particular demonstration, is there kind of a "but for" feeling? If we haven't moved many people out and certain things have risen as challenges, is there any way

from the information we do have to know what was the "but for"? You know, but for housing, let's say, that turned out to be -- or whatever. Will we at least be able to, if not know directly infer from the evidence what the missing ingredients might have been?

COMMISSIONER BURWELL: It's a complicated question. At the same time that the demonstration was going on, States were greatly expanding their home- and community-based services programs in general, so there was a lot more opportunity for people just to be transitioned out of nursing homes, anyway, outside the demonstration. I wasn't part of the evaluation, but I do understand that lack of housing being in the effort to identify people who express a desire to leave nursing homes and live in the community, which in itself was a complicated question. Finding available housing and setting up the support structure needed to bring someone into the community and have them supported in a community-based environment was a very difficult job, because often these people are people who do not have a formal care structure at all, and it's just varied.

So there is a related housing policy issue here

in that Medicaid cannot pay for room and board. States cannot buy housing for people. There's a lot of kind of pushing of the envelope going on, and I think that is a -- in regard to what's called housing-related services, so it's housing counseling, finding housing, paying initial security deposits so people can find housing, all those kinds of things. And there's an internal discussion going on within CMS around how far that envelope can be pushed.

I do think that there are lessons that can be learned from a demonstration around what kinds of support services not normally covered under home- and community-based programs are needed to effectuate transitions in the community, and they can be transitional-type services. Housing is just a large issue more generally than just a lot of LTSS populations too. They cover all kinds.

The relationship between the expansion of home- and community-based services programs in general and the demand that that has created and the lack of affordable housing is somewhat related but a larger policy issue.

CHAIR ROSENBAUM: When Olmstead came down in the late '90s, it was sort of the handwriting was on the wall. It was on the wall as early as the Pennhurst case, and so,

I mean, this is a longstanding issue. And an interesting question, I think, for us all on the Commission is, Should we expand the horizon a little bit of our recommendations to the extent that our recommendations for dealing with a problem that shows up is a Medicaid problem, Medicaid spending problem? But requires solutions outside of Medicaid is an issue.

Toby.

COMMISSIONER DOUGLAS: I was going to ask how the evaluation is assessing MLTSS, kind of how the impacts the MLTSS compared to Money Follows the Person, just understanding kind of what -- back to kind of the "but." What are the levers that work? I mean, obviously, on the MLTSS, the same issue on housing comes up, and it's a big issue, although there is a lot of pushing the envelope on all the supports and everything around boards, not the room, but the board side of it. So I'm just wondering, Is that being kind of looked at as kind of a comparison?

MS. VARDAMAN: In addition to the evaluation reports, Mathematica, as the evaluation contractor, has also been putting out field reports, and one of them did focus on the interaction between Money Follows the Person

and Managed LTSS. And states are doing different things. Some states may have started their Money Follows the Person Program prior to implementing MLTSS, and so, in some cases, states have transition coordinators outside of the plans who are supposed to coordinate with the plans. In other states, they've integrated Money Follows the Person with MLTSS, and so really, they've kind of laid out the various ways that states have done that, but I can do a little more digging to see what some of the results have been.

CHAIR ROSENBAUM: Chuck and then Andy.

COMMISSIONER MILLIGAN: I really liked the way Brian framed it.

I want to just sort of talk about MFP from a couple of directions. I was Maryland's Medicaid director when we were doing a lot of the MFP work, and a couple of different things just to introduce in the top conversation. One is that people coming out of nursing facilities have the ability to sort of jump the line for a waiting list for HCBS waiver slots, and MFP could benefit from that. Again, it's just those peculiar Medicaid dynamics of having to go into a nursing home to go back out to the community again.

But one of the aspects of MFP is that originally

as passed, MFP had, as I recall, a six-month length of stay kind of in a nursing facility, and then it was reduced, I think, to three -- I could have that wrong -- to try to make sure that somebody could go back home again without having given up their housing necessarily, without having lost their informal supports if they had infrastructure. So there is a relationship, I think, that we should be looking at about housing security and informal care giving because the longer somebody is in a nursing facility, the more likely it is that they're losing their home, they're losing their apartment, they're losing their source of informal supports.

And two other quick points, one about MLTSS. I think one of the challenges -- and my current role is with United's MCO. We have managed long-term care. We do this kind of work. It's part of our state contract. The housing is a tricky part, and security deposits for apartments and E-Mods and all of that kind of stuff, there is an issue about how much you can put that in an encounter and how you can put it into rates. So I just want to sort of flag that point.

And I guess the last one I want to come back to

is, Brian, about your missing $3.8 billion. Just to use an example of how Maryland spent some of that money, that wasn't directly related to services. One of the challenges in a lot of this is the whole throughput of the eligibility determination leading to plan of care development, leading to finding a case manager, leading to finding care coordinators. If somebody isn't on Medicaid, they're in a nursing home, and they spend down or whatever to get on Medicaid, there is the application process they have to go through -- getting a waiver slot, so to speak, getting a care coordinator, getting a care plan put together, getting a case manager, getting service providers, and that has lots of people in that chain.

One of the things that Maryland did is we built a tracking system that had sort of read-only access for each person who was in that approval process to only see their piece of it but for us to track where it was sitting, how long was it sitting in an eligibility office waiting for somebody to do the eligibility determination, how long was it sitting where the plan of care needed to be developed and approved by our state department on aging, how long did it sit to get the case manager to assign service

coordinators to organize. So there is infrastructure, and I think there's some utility to that because that throughput enables a much quicker placement with services.

But, again, I'll wrap up by saying, Brian, I completely agree. Having more visibility into where that money was spent makes sense to make sure it was spent to advance the cause of HCBS.

CHAIR ROSENBAUM: Andy, why don't you have the last word on this segment.

COMMISSIONER COHEN: I just was interested. I have two questions, really.

One was, Was there tracking of the outcomes for the people who left, and how many of them were able to stay in the community over a period of time and learnings from that?

And then the other question is, Was there any tracking of whether bed capacity was or could have been reduced in any location because of this, like nursing home beds?

MS. VARDAMAN: I'm not sure about the second. For the first, evaluation did look at re-institutionalization, and the rates were generally quite

low.

CHAIR ROSENBAUM: Great. All right. Thank you so much. It was a great discussion, and let's move on to our last presentation of the day on opioids.

All right. We're going to start now. Okay. Amy, take it away.

PRESCRIPTION OPIOID USE IN THE MEDICAID POPULATION

* MS. BERNSTEIN: Here we go. Last of the day.

CHAIR ROSENBAUM: You have been waiting so long.

MS. BERNSTEIN: I have been. It's a bad time for my voice to go.

All right. So, yes, we are going to talk about the opioid epidemic. Today, we are going to do a general high-level descriptive analysis of prescription opioids. Opioids, as you probably all know, include things like oxycodone, hydrocodone, codeine, morphine, fentanyl, and methadone. Heroin is a nonprescription opioid, which is sort of out of the purview of Medicaid data since Medicaid does not generally prescribe heroin to its enrollees, so it is not reflected in claims data.

The opioid epidemic is, I think, pretty commonly

known by all of you. It's in the papers almost every day. There is legislation. It's a major, major issue in almost all States now. Between 1999 and 2010, there's been an 86 percent increase in the number of deaths based on CDC data and a 34 percent increase in the number of heroin overdose deaths, but a substantial portion of those deaths are from prescription opioids. And I believe prescription opioids or opioids in general deaths are almost on a par now with car accidents and other accidents for non-elderly people.

It's also very expensive. It's hard to get actual estimates of the true cost of opioid use and misuse, but one study estimates that it's somewhere between 53- and $72 billion a year, and that includes both the health care and treatment cost but also costs of the criminal justice system, being incarcerated, and all of the other bad things that go with misusing opioids. The National Survey of Drug Use and Health estimates that there are about 2 million people who have opioid dependence, and that's based on a survey of the non-institutionalized population. And I think it's pretty commonly accepted that opioid deaths have been increasing.

It's of particular importance to the Medicaid

program, which is disproportionately affected by the opioid epidemic. Here are three anecdotal -- excuse me -- non-anecdotal research studies, so they are not anecdotal. They actually looked at data, and New York found that Medicaid enrollees were prescribed pain killers at twice the rate of non-Medicaid patients. Washington State found that Medicaid patients were at three to six times the risk of an overdose, and an Arizona study found that Medicaid paid for more than half of all opioid-related emergency department admissions. So it's a big deal to the Medicaid program.

So I am going to give you some data. This is our first foray into the world of prescription opioids in Medicaid, and let me first, of course, give you the data caveats and limitations.

We used 2010, '11, and '12 medical statistical information system. That's not a limitation; that's the data. But we did exclude dually eligible and partial-benefit enrollees because most of their prescription drug use is through Medicare, not through Medicaid.

We excluded full-year institutionalized enrollees because, generally, their opioids and other drugs are part

of the nursing home stay, so it's sort of hard to tease out what they got when they were in an institution.

We excluded enrollees with cancer non-malignant -- I mean with malignant cancer. We left in people with non-malignant cancer, but people with malignant cancer are generally excluded because they use opioids differently than other people. And we had to exclude some States because of the incomplete encounter data.

And let me just again emphasize that we are only looking at prescription opioids. We are not looking at illicit drugs, and by illicit drugs I mean both the non-prescription use of prescription drugs. So if you, you know, take an opioid from your parents' medicine cabinet or you buy it on the street, that's considered illicit. We don't know about that in the claims data.

And given that we have prescriptions in Medicaid we don't know if they were actually consumed by the enrollee. So you may have gotten an opioid prescription from your dentist after your wisdom teeth were out and not taken the whole prescription. So not everybody who was prescribed an opioid, that we counted as a user, because they were prescribed opioids, might actually have taken it.

So, results. So for 2012, which is the most recent year for which we have the comprehensive MSIS data, Medicaid paid for over 34 million claims for opioid drugs, which represents more than $500 million, and again, this is only a fee-for-service because we don't -- we can't separate out the cost of encounter data, so this is not nearly as much as was actually spent, but it's before rebates. So it's a big number but it's probably an even bigger number.

The total number of claims actually decreased between 2010 and 2012, and this is consistent with other data. Prescription opioid use in many states has actually decreased, in part due to the various policies and procedures that I'm going to present later, and also opioid prescriptions, as a share of all prescription drug claims, decreased. So there's a little bit of good news.

So, characteristics of the opioid prescription users. So 15 percent, overall, of all of the opioid -- all of the people that we had at least one opioid prescription, represents 15 percent of all Medicaid enrollees. This varies by state, and I know you're going to ask me which state is the highest and which is the lowest, and I talked

with Anne about this and I was going to bring the state table, and it's the one table I have a whole list of background materials and that's the one that I forgot. But I can -- I do remember that West Virginia was the highest. So if anybody is interested in that, that's the one number that actually -- I believe it was 24 percent of people in West Virginia.

It differed by basis of eligibility. People who qualified on the basis of a disability were more likely to be prescribed an opioid than people who were not. This kind of makes sense, given that people on disability are probably more likely to experience pain. Many people who qualify for disability qualify on the basis of back pain or neck pain and thus might be prescribed opioids. It's 13 percent of enrollees who don't qualify on the basis of a disability. And women were more likely to have an opioid prescription than men, and this is consistent with other data that women are more likely to use psychotropic drugs, in general, more than men, and actually all drugs, because they're more likely to go to the doctor.

The number of opioid prescriptions increases with age, and again, this is -- makes some sense, given that

probably pain increases with age -- back pain, neck pain, other kinds of chronic pain, arthritis. But the one exception is for non-disabled young adults.

We also looked at sort of the number of prescriptions and how many, for lack of a better term, pills were prescribed over what time period. Most opioid prescriptions were for one or two months, relatively short term. Half of them were for less than two weeks. About one-third were for about a month. A month is probably a -- sort of a cap, given that a lot of the programs that control opioid use limit prescriptions to a month. So it's kind of like insurance that limits the number of days you can be in the hospitals, so it may come out to be 30 days because that's what the cap is. However, there were five percent that had more than a month prescription.

And we looked at sort of what we would call possible predictors of misuse, which is going to many pharmacies or going to many prescribers. This doesn't necessarily mean that they're abusing opioids but it has been used by others to sort of be a proxy for people who may warrant further scrutiny. I mean, you might have a lot of different providers and they might each give you

opioids, but, in any case, about five percent are enrollees who had an opioid received prescriptions from five or more prescribers, and about two percent filled them at five or more pharmacies.

So, how does Medicaid, or how do Medicaid programs sort of treat or provide services for people with, let's call it opioid misuse? So for the people who are determined to have substance use disorders, among them being opioid dependence, states vary widely. Substance use disorder treatments, in general, except for sort of mandatory, medically necessary services -- you know, if you overdose and are dying and go to a hospital, that would be medically necessary, but pretty much everything else is optional for substance use.

And I should remind you that we posted a table -- actually, a series of tables -- on our website, on the MACPAC website, which describes substance use treatment under state plan amendment, in general, by state. So you can see sort of the wide variation in substance use treatment across states. And I forgot to say, at the beginning of this, that most of these data were compiled and collected by Sarah Melecki, who has left us. So I am

deeply sorry that she is not here to present this, but she did that table and pretty much everything else that you're seeing here. And then she left, so I'm presenting it.

In any case, all states cover naloxone, which is used primarily for overdose -- opioid overdoses -- to sort of neutralize the effects of opioid overdose, and naltrexone, which is used for alcohol and opioid -- it sort of reduces the buzz. And every state also covers -- I'm going to say the name wrong -- that B thing -- buprenorphine.

[Laughter.]

MS. BERNSTEIN: Yes, buprenorphine. Yes. And they either cover it on its own or with -- also in combination. Other benefits that would sort of benefit opioid misusers would include detoxification. Thirty-two states cover inpatient and 34 states cover outpatient detoxification, 24 states cover psychotherapy, and 14 states cover peer support for substance use disorders. No states have, on their website, that they pay for 12-step or other programs. That's a little misleading because a lot of times they're free and they're sort of included in other parts of therapies. So it's not that they're maybe not

covered but nobody sort of touts that they cover them, that we can find. And I should also say this was all based on things that we found on the websites. So just because we didn't find it doesn't mean a state doesn't do it. So I am hoping that states don't call us up and say, "We cover that," and we have the wrong number. But this is what we found, from publicly available information.

In addition to state plan services, many behavioral health and substance abuse enrollees -- substance use disorder enrollees; excuse me -- are in waiver and demonstration programs, and here are some of them that actually focus on substance use disorders and opioids in particular. Section 1115 waivers may include substance use disorders, include opioid misuse. There are three Medicaid health home models that focus on opioid dependency that have case management and other substance use treatment, and then there are delivery system reform incentive payment, sort of programs within their overall payment scheme, that have different -- that emphasize different treatments and other ways to address opioid misuse.

So, what are states doing to try to control

prescription opioid use and abuse? And what a lot of people have heard about are what are called patient review and restriction programs, otherwise called lock-in programs, where at-risk patients are identified and then they have to go to sort of one place to get their prescriptions, so you can monitor sort of how much they're getting, and they aren't going other places where, you know, they might be getting additional drugs. So it's easier to sort of control the supply if they can only go to one place.

States vary, though, in the criteria used to identify patients, the periods, other factors. There's -- in your appendix tables there's a pretty detailed list of all of the different dimensions of how these vary by state. It also -- they also vary in whether they implement these programs for their managed care or their fee-for-service programs. So 18 states use them only in their fee-for-service, 3 states use them only in their managed care programs, 28 use them in both, as of 2015. That's probably changed by now.

Quantity limits, Jane mentioned in her presentation. That's basically you can't have more than a

certain number of pills in a certain number of times, a certain time period. They can differ on whether they're short- or long-acting, and five states don't have any quantity limits at all but they do have other programs. So it isn't like they're not paying attention. It's just that's not one thing they chose to do.

Prescription drug monitoring programs are a little more -- a little broader. They're sort of more research-y. They are generally done at the state level and they collect information from opioid dispensers. So we have, at the beginning, sort of focus on the patient or the opioid user. Then we sort of focus with the lock-in. Then we have quantity limits. That's more the provider. You can't, you know, prescribe more than a certain amount. So you can focus on, you know, programs to keep the prescribers from giving out too many. And then you have sort of the suppliers, like the pharmacies.

So in PDMP programs you collect information on the dispensers to see sort of how much they're giving out, and individuals, again, found to be at risk are often enrolled in these lock-in programs, and then the providers are sort of counseled and dealt with in different ways,

depending on the state. These are most commonly operated by the state Boards of Pharmacy, but they can also be operated by state agencies, and all but one state has a PDMP which currently has legislation pending. That would be Missouri.

And the issue is how the states work with the Medicaid programs. So there are several states that have these sort of databases, but the Medicaid programs and providers don't necessarily have access to the information. So in 31 states they do, but in the other states they don't. And again, this might have changed a lot since 2014, and we will update it soon.

And drug utilization review, again, is similar. It's an ongoing process, and basically looks for inappropriate prescribing practices that are often operated by a contractor, and all states have one.

And then you have sort of other things that are done. Preferred drugs lists, which are sort of a kind of limiting on the number of -- it's more a quantity limit, again, or a restriction on what drugs can actually be prescribed. You can have provider education programs and patient education programs, and those are recommended by

CMS in a presidential letter that came out and by the CDC and by others, and patient education programs. And there's some consensus that you sort of need to do more than one of these things, that any one of these is not necessarily going to get you where you want to go.

We have not, at this point, consistently and thoroughly gone through all of the evaluations of all of these programs. I know everybody wants to know which of these works the best. The few meta -- not meta-analyses but sort of syntheses -- research syntheses that have been done haven't really come up with a magic bullet yet, and part of that is because, as I sort of emphasized at the beginning, this is just prescription opioids.

So, for instance, there was one study that was done in North Carolina on lock-in, and it did reduce cost to the Medicaid program, and it reduced prescriptions in the Medicaid program, but deaths didn't decrease because -- and, actually, out-of-pocket payment increased because people were just going elsewhere to get their opioids. So if you sort of don't have a big handle on the whole picture, it's harder to evaluate these programs, and that is harder to do because illicit drug use is harder to

measure than licit -- is that a word? -- drug use -- prescription drug use.

So for -- and also, as I mentioned at the beginning, sort of the cost of opioid misuse is hard to sort of calibrate with other things, mainly -- the same reason that other costs are hard to calibrate for a specific condition. It's sort of like behavioral health in general, because there are so many comorbid conditions and so many other things going on that you sort of -- it's hard to attribute the cost to the actual opioid addition when there's lots of other things going on.

That said, we could look at sort of total costs -- I'm sort of skipping down to number two here. We could look at total costs of people who have prescription opioid use and see what their comorbid conditions are, and sort of how much of the costs are for behavioral health service and how much are for medical or LTSS. We could also focus specifically on medication-assisted treatments. There was just a study that came out recently that looked at this and concluded that they were not used as often as they had hoped, that -- and, in part, because they're optional Medicaid benefits, so we would have to do that sort of at a

state level, depending on what was actually covered.

We could also look at just utilization that -- medical care utilization from claims that's associated with opioid dependence, where there's actually a diagnosis that has opioid on it, like, you know, fetal -- I'm totally blocking on the name -- abstinence syndrome, or deaths where opioid is listed as the death, or emergency department visits where some, you know, opioid is listed as the reason for the opioid -- for the emergency department visit.

And, of course, we will be monitoring any of these evaluations as they come out. You know, we will do a more -- we can do -- we could do a more complete, you know, sort of synthesis of what's in the literature. But again, at first glance, and from the consensus conference that have published results, there does not seem to be a magic bullet for the strategies that I've listed. They tend to focus more now on treatment and sort of treatment of the person who is identified as the opioid user, and not as much on controlling supply of prescriptions, although that's a good thing to do to control costs.

And then the thing that I didn't -- the one thing

that I didn't include on this list, which I, of course, remembered later, was we could look at the National Survey of Drug Use and Health which does have illicit drug use, and compare Medicaid and private use and general health characteristics. We don't sort of know a lot about, you know, managed care or not managed care or anything about the Medicaid program, but we could compare private and Medicaid and uninsured people's use of opioids. So that is something else that we could do in the future to round out the portfolio.

And again, this is very descriptive, this is prescriptions, and it's a start, so we're very interested in where you would like us to go from here.

CHAIR ROSENBAUM: Okay. We have Gustavo, Brian, Penny, Kit.

COMMISSIONER CRUZ: So, great presentation. Thank you, Amy.

I just have one question. Do we know the number of people that are being treated for opioid abuse by Medicaid, that obtain their opioids through Medicaid?

MS. BERNSTEIN: We have not conducted that analysis yet. The survey from, I think it was IMS, looked

at two specific Medicaid assisted treatment therapies for Medicaid enrollees. We could do that in the future, and it would have to be drugs that were prescribed by Medicaid and treatments prescribed by Medicaid, because that would be the only thing that would be in the claims data. So that's sort of number one on the list.

COMMISSIONER CRUZ: Okay, great, because --

MS. BERNSTEIN: My question, I guess, to you would be, we could look at therapies that Medicaid pays for, but -- so if they paid for medication-assisted treatments we could look at that. The question then is whether we would also look at other substance use treatments that go along with that.

COMMISSIONER CRUZ: No. What I was thinking it -- I mean, if we are going to align some of the control that we can do through the Medicaid program, in terms of limiting prescriptions and stuff like that, it would be useful to know if the people that are actually being treated by Medicaid are actually obtaining their drugs through Medicaid or are in the streets or something like that. So those control mechanisms that we may propose are not necessarily being -- going to be effective with this

population that we're actually treating.

MS. BERNSTEIN: We could certainly look at use of medication-assisted treatments and whether they -- there's the group that received their opioids through Medicaid and a group that didn't. So we could certainly look at that in number one.

CHAIR ROSENBAUM: Brian.

COMMISSIONER BURWELL: So 78 people die of opioid overdose every single day. Over 200,000 people have died over the last 10 years. More people have died from opioid overdoses than have died of AIDS. I've heard it characterized as the largest man-made epidemic ever in the history of mankind. So the numbers are terrible and they're rising.

I'm a little concerned that we're using MSIS data to look at this issue, because anything from 2012 is way old, in terms of this issue, and the rate of opioid-related overdoses has just skyrocketed in the last five years. I mean -- so there are a lot of issues. You know, OxyContin was initially marketed as not -- as a safe drug. Biochemically, it's exactly -- it's almost exactly the same as heroin. It's heroin. It's addictive after a very, very

short period of time. So, you know, like, oh, the average prescription is seven days. People have -- you know, can become addicted after three doses. So there's a whole history there. No need revisiting.

My issue is this is a very critical issue. There's a lot of different players involved in this, trying to address this problem across the federal government. I don't know what particular role we could play. I kind of think -- you know, the NGA has a huge -- has a very large initiative. A lot of the governors have signed up on this. They've made a set of recommendations to Congress. I'm wondering if we can -- you know, we're not the states, we're not -- you know, we're a different type of advisory body, but at least I'd be interested in hearing from them at a future meeting and going over their recommendations, because -- and seeing how much we might align ourselves with those recommendations. I think -- or a recommendation from both NGA and MACPAC would have kind of greater weight.

But I'm really -- I guess my own priority is it's time for action and the more that we can provide policy guidance to Congress around this, I think we can help.

I do have -- I just went to the NASHP annual

conference. There was a pre-conference on this epidemic. Some people from MACPAC were there -- Jessica, Sara. There was a very good presentation by the State of Washington, from a person that I would highly recommend, and it's a good example of state that has really taken this on, and has had some success in combating the epidemic, and I would think could be highlighted as a case study of a state that has responded successfully.

CHAIR ROSENBAUM: I have Penny, Kit, Toby, Sharon.

COMMISSIONER THOMPSON: These are both good comments. I did want to go to the data question for a second. I had the same issue about age of the data.

The other question that I had, Amy, is how do we account for drug diversion in this kind of data? So when we do this analysis, we're acting as though, because a claim was submitted for someone to receive a drug that they actually received it, and we know, in this case, that there is a substantial issue of these drugs being diverted elsewhere.

MS. BERNSTEIN: We don't.

COMMISSIONER THOMPSON: So is there any data

around that, that we could look at to help us understand how to approach some of this with the caution of -- what the claims data purports to show may not be the reality of what is actually happening.

MS. BERNSTEIN: Which it isn't. I mean, we know it isn't. We don't -- as my limitation slide showed, I mean, we don't know if they took it, we don't know if they gave it to somebody else. I mean, that's claims data. We know what was paid for. So the point of that analysis was more to give sort of a ballpark that it's a big number. It's not the right number.

Are there other data sets? I mean, the IMS data, again, you know, it's sort of like if you have a prescription, you don't know where that prescription went unless you talk to the person. So that would be a reason for looking at the NSDUH data, which -- where they actually ask people if they use drugs illicitly. But then you don't sort of have the prescriptions side. So it's -- you know, there are sort of illicit drug data and then prescription drug data, and it's a whole person, unfortunately.

So I am not aware of a data set that you could use to look at diversions unless it was a specially

designed study. Nothing at the national level that I know of. That doesn't mean there --

COMMISSIONER THOMPSON: Okay. And then the second thing. It seems to me like, in thinking through, because I totally agree with Brian, and I think, Amy, you set this up for us. I mean, this is a national tragedy. And so I have some of the same reaction as Gustavo in the sense of, you know, it's particularly tragic if we're creating the problem that then we have to solve, from both the program standpoint and from the point of view of actually creating threats to health rather than solving them. So I am very interested in this question of whether or not we can understand the extent to which we're contributing.

And I think on that side, I didn't see a lot of mention of looking at prescribers, and so I think that's another dimension of this to consider, not just what's happening in terms of individual beneficiaries but what is the pattern of prescribing that's happening in the country. And I think that -- thinking about that question might also be helpful.

CHAIR ROSENBAUM: I've got Kit, Toby, Sharon,

Sheldon.

COMMISSIONER GORTON: So following up on the data question, I agree 100 percent the MSIS data is too old. The three largest PBMs in the country, as we were talking about a little while ago, reached to 150 million Americans. That's a reasonable sample of the population. And it seems to me that it's time to explore accessing the real-time data that they have available about what's been dispensed and walked out the door. And I think that an aggregate level, state level, whatever else -- you know, you might have to pay them for the work or, you know, maybe they'd do it as a public good. Who knows?

But, you know, it seems to me to be worth trying to tape into those other data sources. The advantage of the PBMs is they're all payer. Right? So they're paying the Part D's, they're paying Medicaid, they're paying commercial. So I think it's worth pushing on that.

We have prescriptions that are provided in sliding scale clinics. FQHCs, free clinics and others -- they often provide medication because people can't get it anywhere else. And while there may not be a prescription for opiates for dental care, because people may have had to

pay cash or sliding scale, they may very well have started, you know, by having their wisdom teeth out, or some other oral procedure, which tend to leave people in a fair amount of pain. So I think it's worth thinking about that.

I was struck that in your discussion of medication-assisted treatment we didn't talk about methadone, which is a big deal, and there's lots to -- well, methadone, it's a heavily regulated program, every state does it, and we ought to be able to --

VICE CHAIR GOLD: It's in her paper. It may not be in front of you.

COMMISSIONER GORTON: Okay. So I -- it didn't jump out at me and it's a big part of the landscape, in terms of how it happens. And in thinking about medication-assisted treatment, one of the issues is, you know, every doc with a shingle doesn't get to do this stuff. Methadone can only be delivered in very certain and highly prescribed ways. Buprenorphine, Vivitrol, and all those things, you've got to have certifications, and there are limits. You can't write more than 100 prescriptions a month, and blah, blah, blah, blah, blah.

I think we ought to be thinking about describing

the infrastructure that exists to provide medication-assisted treatment, and I think what we'll find is given the size of the epidemic, the national infrastructure for delivering these services is simply not big enough, because it was constructed in the '70s around what people perceived to be a much smaller problem. And so, you know, I would encourage us to look at not only what these drugs are and who is taking them but what are their control mechanisms and how that sort of gets in the way.

And maybe in the interest of time I'll just stop there. It's a very important topic. I think it's timely. I think MACPAC has a role to play in helping drive the national conversation about it, and I'm glad that you have started this work.

MS. BERNSTEIN: I'll just say there are 17 states that do not list methadone as a drug, and part of that is it's decreasing because they're using the other drugs instead, because methadone has to be prescribed in clinics. And so -- anyhow, I should also say, which I neglected to say, and I should have said, is that we are going to be posting the tables at the end on the Web as well, and this is only a subset of them. We have one that lists all the

drugs that they use for treatment, and that includes methadone. So I'm sorry I didn't include that.

COMMISSIONER GORTON: Does -- have we put together a description of the limitations around what it takes -- you know, what are the barriers to access to those things? It's interesting that the barriers to access to methadone are 100 times greater than the barriers to access to heroin. And so it's just something to be taken into account as we think about how to address this, as others have said, self-inflicted epidemic.

CHAIR ROSENBAUM: Toby.

COMMISSIONER DOUGLAS: So data, I agree, is really old, and the thing that we have to remember is with Medicaid expansion, it's really changed Medicaid's role in this, you know, with this epidemic, because so many of the population is now eligible, and obviously in the states that have expanded. So I think that's one piece of it.

And it gets to kind of where -- there's the front door -- how do we stop it, on the treatment side. I do think it's probably more of a qualitative, you know, evaluation or looking at some of the things that are going on. Obviously, there's a movement trying to look to more

evidence-based continuum of care that builds on what's called the ASAM criteria that are driving, you know, CMS and states are moving towards. And it gets to that tension between medication-assisted treatment and methadone and then all the other levels of care, and kind of how that's working, assessing that. I think we need to monitor that.

And there's that tension, at least in some states, say, you know, methadone has been such the driver of trying to move to medication-assisted treatment. It's not easy because of the -- kind of the interests that are there. So that's just kind of part of how to get to an evidence-based system.

So I think it's more of a qualitative on some of this than we're going to be able to get with data, because of the newness of the population that we're now having to cover under Medicaid.

CHAIR ROSENBAUM: Sharon.

COMMISSIONER CARTE: I just want to reiterate some of the points. I mean, being from West Virginia this has been such a dismaying epidemic, which is why I agree with Kit that we should just try to elevate this to a whole other issue. For example, I was heartened recently that

West Virginia had put into effect one of these prior authorization review programs for opioids. However, looking into it further I found that it was only for 90-day prescriptions, and as Brian mentioned, the short-time addiction that you can have, and Amy has the point that almost half of the opioid prescriptions were for short-term use, with a supply of less than two weeks.

Again, you know, we could spend lots of time chasing ourselves or using up resources, going in circles, doing -- with little effect, and then, again, the methadone issue, where West Virginia is one of those states where we've seen opioid -- we're starting to take action to decrease, but the population switches into heroin. It's just very serious.

CHAIR ROSENBAUM: Thank you. We have two more commenters, Sheldon and Peter. I want to --

COMMISSIONER CARTE: No. Let me just --

CHAIR ROSENBAUM: Oh. Sorry.

COMMISSIONER CARTE: -- let me just add --

CHAIR ROSENBAUM: Yeah.

COMMISSIONER CARTE: -- one last -- this is anecdotal but since it affected CHIP. I recently learned

from a CHIP parent that her 17-year-old, who had a sprain due to a football injury, was given a 10-day supply of 30 hydrocodone pills, which also points to a great need for physician re-education.

CHAIR ROSENBAUM: So we have two more commenters, Sheldon and Peter. We do still need a public comment section, and we need to be out of this room in 17 minutes.

So Sheldon and Peter, and then let's go to public comment and adjourn.

COMMISSIONER RETCHIN: That's a lot of pressure.

CHAIR ROSENBAUM: [Speaking off microphone.]

COMMISSIONER RETCHIN: Yeah. I actually was thinking of the commercial where the security monitor says -- I don't know if it came to anybody else's mind -- that we have an opioid problem.

So I -- you know, the retrospect of analyses, we all know we have a prescribing problem. But I just wonder, one of the roles I do see of MACPAC is monitoring best practice across the 50 states.

CHAIR ROSENBAUM: Yes.

COMMISSIONER RETCHIN: A lot of experimentation going on. And I do wonder, in real time, in an emergency

room, does every state now have the ability, or maybe even the requirement of physicians to access the prescribing -- the current prescription load for every beneficiary? Because Virginia did that. I don't know about Ohio?

MS. BERNSTEIN: Say that again.

COMMISSIONER RETCHIN: So I'm in an emergency room. I have a beneficiary in front of me, complaining of pain, wants -- and I mean just writhing in pain. I want to know how many -- what have they been prescribed in the last six months.

CHAIR ROSENBAUM: You've got a basic health information transmission issue. It's not a Medicaid issue, I assume. And one of the things that I was going to raise was the potential effects of the new -- what's called the Part 2 rule -- on Medicaid programs' ability to put effective monitoring and ready access to information about drug exposure into practice, and not to say that that's a bad thing, Part 2 is a bad thing, but there is a real issue here, in terms of instituting best practices and information exchange that falls outside of the Medicaid program, clearly.

COMMISSIONER RETCHIN: So maybe, Kit, you

remember, but I know in Virginia -- maybe it's all payers; I don't know -- but you're in an emergency room and you can see that a prescription has been written for beneficiaries.

COMMISSIONER GORTON: Massachusetts just passed that and expanded it. The program existed previously, but it was voluntary, and so, of course, none of the prescribers used it. But it's now been, in the last six months, been made mandatory. There are issues. There are Part 2 confidentiality issues and balancing patient privacy with, in fact, protecting them from themselves by knowing what they've been doing and what people have been giving them is a thorny issue that does, as Sara says, expand farther than Medicaid. But we are seeing the new New England compact. They're adopting that as a best practice, and I think we may -- the NGA, I taught, actually, it's one of the things that NGA is recommending.

COMMISSIONER RETCHIN: I'll stop there.

CHAIR ROSENBAUM: I do think -- and I'll throw this in here and be quiet and go right to Peter -- but of the things that I think we do need some additional work on, as a Commission, because I agree with you, Sheldon, that

the issue for us, it seems to me, more than anything, is how can Medicaid better participate in effective intervention and treatment, because we're being hit so badly by the -- the programs affected so much by this epidemic, is to understand what maybe some of the most crucial issues, which fall entirely outside of Medicaid. And so we're going to have to get smart on things.

COMMISSIONER GORTON: So, Sara, I would just add prevention intervention and treatment, right, because Medicaid --

CHAIR ROSENBAUM: Yes.

COMMISSIONER GORTON: -- as Sharon just told us, Medicaid and CHIP have a big role in making sure that kids don't end up --

CHAIR ROSENBAUM: Yes, doing drugs.

COMMISSIONER GORTON: Yeah.

COMMISSIONER RETCHIN: The one thing -- the one area that I will say falls in the cracks here that maybe MACPAC should at least monitor, and that's work force. No one else provides oversight. Remember, that was part of the ACA; never funded.

CHAIR ROSENBAUM: Okay.

[Simultaneous discussion.]

[Laughter.]

CHAIR ROSENBAUM: So Peter, you round us up.

COMMISSIONER SZILAGYI: Yeah, just very, very quickly. By the way, Sheldon, I moved two years ago from New York, where this was required, to be looking up for patients, to California, where it's just starting to ramp up. So there must be an enormous -- there must be enormous variability across states.

Just two quick points. Many years ago I did a study with a faculty member where, a self-reported national survey, 10 percent of adolescents had used opioids. Most of them were obtained from their parents, unbeknownst to their parents. So diversion happens in many, many ways.

But I was just -- many people made exactly the same point I was going to make, which is I think -- I was trying to think of what the best contribution MACPAC could have, and I really think getting into the world of best practices and sort of qualitatively looking at Medicaid programs or integrated with other programs, what is working really, really well to complement some of the old data that we have is probably our best fit.

CHAIR ROSENBAUM: Public comment please.

MR. GORDON: Stuart Gordon with State Association of State Mental Health Program Directors. I can't even remember the name of my own organization.

So I want to remind you all of the role SAMHSA has in this area. I want to remind you all that every state has a state mental health and state substance use agency. The state substance use agencies, about 18 percent of what they spend comes from the block grant, about 22 percent of what they spend comes from Medicaid, the rest is state agency, or state money -- state-only monies.

So when you're looking at this issue don't just look at it at as a Medicaid issue, and remember, SAMHSA plays a huge role in developing best practices. They've got a whole website where they encourage the use of best practices.

The other thing I would say -- and this is not a paid political announcement -- but Congress, a couple of months ago, passed CARA, the Comprehensive Addiction Recovery Act. There are lots of programs in there that are intended to address this issue. The administration asked for $1.1 billion to fund all of the programs in that bill,

and so far they've gotten none of it.

Thank you.

CHAIR ROSENBAUM: Thank you. Any additional public comments?

PUBLIC COMMENT

* [No audible response.]

CHAIR ROSENBAUM: All right. We are adjourned.

[Whereupon, at 5:20 p.m., the meeting was adjourned.]