Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

Hall of States
National Guard Association of the U.S.
One Massachusetts Avenue, NW
Washington, D.C. 20001

Thursday, January 22, 2015
1:05 p.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
SHARON L. CARTE, MHS
DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
GUSTAVO CRUZ, DMD, MPH
PATRICIA GABOW, MD
HERMAN GRAY, MD, MBA
MARK HOYT, FSA, MAAA
YVETTE LONG
NORMA MARTINEZ ROGERS, PhD, RN, FAAN
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
PATRICIA RILEY, MS
SARA ROSENBAUM, JD
PETER SZILAGYI, MD, MPH

ANNE L. SCHWARTZ, PhD, Executive Director

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1 P R O C E E D I N G S [1:05 p.m.]

2 ### **WELCOME, UPDATES, AND INTRODUCTIONS**

3 * CHAIR ROWLAND: Good afternoon. I'd like to convene this session of the Medicaid and
4 CHIP Payment and Access Commission, and I'd like to start the session by welcoming our new
5 Commission members whose appointments began in January of this year, and to ask each of them to just
6 briefly introduce themselves, not just to us but to those who are joining us today and to have on the
7 transcript their welcome to the Commission. And I'll start with you, Chuck.

8 COMMISSIONER MILLIGAN: Hello, everybody. I'm Chuck Milligan. I now work at
9 Presbyterian Health Care Services, which is in Albuquerque, New Mexico, having moved there recently after
10 running the Medicaid and CHIP programs in Maryland and other things along the way. And I'm really
11 happy to be here and to learn from and try to contribute to this process.

12 CHAIR ROWLAND: Yvette.

13 COMMISSIONER LONG: Hi. Good afternoon, everyone. I'm Yvette Long. I am a mother
14 of a child that is currently receiving Medicaid services. She's a severe asthmatic. I'm also a case manager
15 with the Philadelphia Welfare Rights Organization in Philadelphia, and I also chair many committees up in
16 Harrisburg, the Consumer Subcommittee and the Medical Assistance Advisory Committee and Income
17 Maintenance Advisory Committee up in Harrisburg, which consists of consumers around the state, which
18 deal with different changes in policies.

19 Thank you.

20 CHAIR ROWLAND: Peter.

21 COMMISSIONER SZILAGYI: Hello, everybody. I'm Peter Szilagyi. Since December 1st, I've
22 been at UCLA. I'm Vice Chair for Research in Pediatrics. I'm a pediatrician, general pediatrician, and
23 I've devoted my clinical life to serving low-income families. I'm also a researcher. Before going to Los

1 Angeles, I was in Rochester for the last 30 years, and I led the evaluation of the CHIP programs in the state
2 of New York. And I think one other relevant role is that I was Chairman of the Board of Directors for 18
3 years for the large Medicaid and CHIP managed care plan in upstate New York.
4 CHAIR ROWLAND: Thank you.
5 Gustavo?
6 COMMISSIONER CRUZ: Hello. I'm Gustavo Cruz. I'm a public health dentist, and I'm
7 currently a senior advisor for a professional membership organization called Health Equity Initiative, and I
8 am an associate professor at NYU College of Dentistry. I have worked both clinically and as an
9 epidemiologist with underserved populations all of my career.
10 CHAIR ROWLAND: Sheldon?
11 COMMISSIONER RETCHIN: Hi. I'm Sheldon Retchin. I'm an internist and actually a
12 geriatrician by training as well. Currently I am Senior Vice President for Health Sciences at Virginia
13 Commonwealth University and CEO of the VCU Health System in Richmond, Virginia. But I'm in
14 transition. On March 1st, I will become Executive Vice President for Health Sciences at Ohio State
15 University and CEO of the Wexner Medical Center at Ohio State as well. While at VCU I had
16 responsibility for the health system, but as well the second largest Medicaid health plan in the
17 Commonwealth of Virginia. It is a safety net institution, and I spent 12 years there as CEO and had a large
18 focus on disadvantaged populations and particularly the Medicaid program.
19 CHAIR ROWLAND: And we will be joined at our next meeting -- she could not make it for this
20 meeting -- by Marsha Gold, who has been appointed to the Commission and has been asked to serve as our
21 Vice Chair. So you will undoubtedly meet Marsha at the next meeting.
22 For today's meeting, we really plan to focus very heavily on the work we are doing and have been
23 doing on the CHIP program, the future of the CHIP program, the implications of some of the changes that

1 may come from decisions around the extension of either CHIP funding or the CHIP program itself.

2 So I'm going to turn to ask our lead person on this part of our report on sources of coverage for

3 children, Chris Peterson, to provide a CHIP perspective for us, and this is at Tab 2 of your briefing books.

4 ### **Session 1: DRAFT MARCH REPORT CHAPTER: SOURCES OF COVERAGE FOR**

5 **CHILDREN IF CHIP FUNDING EXPIRES**

6 * MR. PETERSON: Thank you, Diane. For some time now, CHIP has been a primary focus of

7 this Commission and its analyses. At our last meeting, we presented preliminary findings from the Urban

8 Institute's microsimulation model of the types of coverage children would be eligible for if federal CHIP

9 funding is exhausted in 2016.

10 In this session, we are bringing the latest projections not only of what children would be eligible for,

11 but what they would enroll in, and how many would be uninsured. But just before we turn to those

12 projections, I want to walk you through the current status of CHIP funding, and then we will update you on

13 the CHIP analysis plan for the current meeting cycle. It's kind of a template we've brought to every

14 meeting to update you on where we are in our analyses. And then we'll turn to those estimates as part of

15 the summary of the draft chapter, which, Commissioners, you have in your materials at Tab 2.

16 The current status of CHIP, there has been no funding extension as of yet, so it is still the case that

17 under current law states will begin exhausting their federal CHIP funds this fall. We are still early in the

18 114th Congress, but no legislation has yet been introduced to extend CHIP. And states are planning now

19 for their state fiscal year 2016, so they are beginning their legislative sessions. Some of them have already

20 started, and this is critical as states decide what to do moving forward.

21 So these are the policy questions that we began to raise in September, and when we started this, the

22 left-hand side was pretty much blank, and now we've filled in those check boxes at least to say we have

23 talked about this during this meeting cycle, many of these multiple times now, regarding, first, coverage,

1 what would happen if CHIP would end; affordability, benefits, network adequacy, the impact on federal and
2 state budgets, and consumer protections as children would move from one source of coverage to the other.
3 In fact, the first four of these are in your materials as draft chapters for the March report, and there's
4 also a brief introduction to that set in your materials. We didn't want you to miss that piece. But the
5 purpose of these chapters for March is to describe the potential losses and problems with children's
6 coverage if CHIP ends under current law. And the hope is that these chapters will do two things:
7 First, we want to provide Congress with the latest analyses of the implications if CHIP funding runs
8 out this fall.
9 And, second, though, we want these analyses to help build toward a potential June analyses and
10 report on CHIP that sets up the discussion for you tomorrow on the broad kinds of potential options and
11 reforms that may be needed if CHIP ends hopefully sometime later than this fall.
12 The rest of my presentation is going to be on Chapter 1, and the speakers that follow will go
13 through these other draft chapters.
14 As I mentioned, we now have preliminary results of how many children would be uninsured in 2016
15 without CHIP. And as you see here, based on the projections, 1.1 million children would become
16 uninsured in 2016 if CHIP ends. So let me just walk you through a little more detail on that particular
17 point.
18 If CHIP were fully funded in 2016, 2.9 million children would be uninsured. That is kind of the
19 baseline of what the Urban Institute is projecting if CHIP were fully funded. Without CHIP, in 2016, 4.0
20 million children would be uninsured. These additional 1.1 million children would represent a nearly 40
21 percent increase in the number of uninsured children.
22 Nevertheless, this 1.1 million may be smaller than some might have expected given that published
23 numbers from the Urban Institute from 2011 were higher. And although we don't delve into these

1 differences in the draft chapter, they were higher then for several reasons, and I'll give you a couple
2 examples.
3 First of all, the early estimates were based on the 2000 census, and based on that, moving to the new
4 census has produced a lower number of children that are estimated. In addition, when those earlier
5 estimates were done, the economy was in worse shape. It is better now. So those factors, along with
6 state decisions and the ACA implementation, all of those have affected these estimates.
7 The second bullet you see there is that most of the children who become uninsured if separate
8 CHIP coverage were to end would be eligible for employer-sponsored coverage, with the remainder eligible
9 for subsidized exchange coverage. And, of course, a key question is: Why would these children become
10 uninsured? And this third bullet illustrates that, that among these uninsured children who are eligible for
11 job-based coverage, out-of-pocket premiums to cover the children would average $5,509 for the year, or
12 13.2 percent of income. We'll talk -- yes?
13 CHAIR ROWLAND: Chris, you're clearly making the point here that we're analyzing children in
14 separate CHIP programs. For the record, could you explain the children we're not analyzing?
15 MR. PETERSON: Sure. So states have the flexibility to create their CHIP programs by doing an
16 expansion of Medicaid or by creating a separate CHIP program, and in some states -- in fact, most states
17 now, they have a little bit of both.
18 What this slide shows is the percentage of spending in the various states that are spending their
19 CHIP money on Medicaid-enrolled children. And so the point is that the maintenance of effort that was
20 enacted in the ACA says that states must maintain their Medicaid and CHIP coverage for children through
21 fiscal year 2019.
22 That plays out differently for Medicaid expansion CHIP states versus separate CHIP states. For
23 separate CHIP states, once the money is gone, they may close down those programs. Even though the

1 maintenance of effort says do this through 2019, in the absence of federal money, they are not obligated to
2 do that.
3 However, for states that have Medicaid expansion CHIP coverage, even though the CHIP money
4 runs out, those states can fall back to Medicaid money, which, although it is at a higher matching rate from
5 the state perspective -- so that will be a burden on the state budgets -- the uninsurance rate will not increase
6 for children because they must maintain that coverage at least through 2019.
7 Now, when the MOE expires after 2019, those states may also roll back, so there could be more
8 uninsured at that point as well. But the purpose of this slide is just to show that those states on the
9 right-hand side have a significant percentage of their projected CHIP spending for Medicaid expansion
10 CHIP kids. So they will have to pay more for their coverage but maintain that coverage, while those on
11 the left are in the opposite situation, relying more on separate CHIP coverage.
12 So now we're moving to the Urban Institute's projections, and here's the big picture I want you to
13 get from this, first of all, is that we are looking at children who are projected to lose separate CHIP coverage
14 in 2016, what would they be eligible for if CHIP ends? The top part, the top half, shows you that they
15 would be eligible for -- half would be eligible for exchange subsidies. The bottom half shows you that they
16 would be ineligible for exchange subsidies because they are offered employer-sponsored coverage.
17 Okay. So now let's walk through that in a little more detail.
18 First of all, this pie chart is among 3.7 million children who would be enrolled in separate CHIP if it
19 were fully funded in 2016. So, Commissioners, this may be a little bit of apples and oranges to the number
20 you may have heard over and over again in our meetings, where we have said that 5.3 million children are in
21 separate CHIP coverage. And there are a couple differences -- there are a couple reasons why this
22 difference exists. Probably the biggest has to do with the fact that when we publish numbers of CHIP
23 enrollment and Medicaid enrollment generally, we are giving numbers of the number of children or

1 individuals who are enrolled at any point during the year, even if for a single month.

2 But you can also look at the number who are enrolled at a point in time, and that will be a smaller

3 number. And that is what the Urban Institute is using here, the 3.7 million enrolled in separate CHIP

4 coverage at a point in time.

5 Okay. So now let's walk through the individual wedges, and we'll start in the big blue part at the

6 top, and then we'll work our way clockwise.

7 So among children who would lose separate CHIP coverage, 43.7 percent would be eligible for

8 exchange subsidies because their parents are not offered ESI at all.

9 The next little blue wedge is these individuals, these children would be eligible for exchange

10 subsidies even though the parent is offered employer-sponsored coverage because that ESI coverage is

11 considered not affordable. That's given the current ACA requirement for affordability that self-only

12 coverage exceeds 9.5 percent of income out-of-pocket for those families.

13 And then the smallest wedge there, the little green one, is that 1.6 percent would be eligible for

14 exchange subsidies because even though the parent may be offered employer-sponsored coverage, that's not

15 available to dependents.

16 So those three capture those who are eligible for subsidized exchange coverage. Now, as we

17 continue around, 19.3 percent are ineligible for exchange subsidies because the parent is offered

18 employer-sponsored coverage and they are not enrolled in that coverage.

19 And the final wedge of 29.7 percent, these children would be ineligible because the parent is offered

20 ESI and the parent is also enrolled in that coverage. And we'll see here in a little bit that the take-up of

21 coverage if CHIP were to end varied substantially between these two wedges.

22 COMMISSIONER ROSENBAUM: Sorry. Just one question. I assume that this is all based on

23 current law where employers have to make an offer -- where the work requirement for employer offers is set

1 at 30 hours a week?

2 MR. PETERSON: Yes.

3 COMMISSIONER ROSENBAUM: So I assume that if Congress and the President were to

4 change to a 40-hour week as triggering the offer requirement, then the number -- I'm just trying to sort of

5 think through in my head, the number who would be exchange-eligible might potentially go up simply to the

6 extent that some of those parents, not -- some of the parents being offered now are working fewer than 40

7 hours a week.

8 MR. PETERSON: Right.

9 COMMISSIONER ROSENBAUM: But we have no way of knowing --

10 MR. PETERSON: I asked about that to the folks at the Urban Institute, and they said they did not

11 think it would change things significantly. And this may be just because we're looking at such a narrow

12 group, you know, so that's not to say --

13 COMMISSIONER ROSENBAUM: So they think we have a significant problem even were the

14 definition of an offer to essentially go up, the offer would go up, we would still have a significant problem.

15 MR. PETERSON: So now, given that prior figure was showing what they would be eligible for,

16 this one, Figure 3, shows what they would be projected to enroll in or not given their eligibility. And this

17 shows that among those 3.7 million, 1.1 million would be projected to become uninsured, 30.9 percent; 1.4

18 million would enroll in exchange subsidies; and 1.2 million would enroll in employer-sponsored coverage.

19 Then the next figure shows among those 1.1 million, well, what would they be -- what are they

20 eligible for and not enrolling in? So, again, starting in the upper left with the blue, 34.6 percent would be

21 eligible for exchange subsidies, and the parent has no offer. You see those other small wedges of 4 percent

22 and 2 percent where employers offer -- the parent is offered coverage, but it is not available to the

23 dependent or fails the affordability test. But the biggest portion here among the uninsured are those who

1 are ineligible for exchange subsidies and the parent is offered ESI but the parent is not enrolled in ESI, 54.3
2 percent. As I mentioned, to get these children enrolled in that coverage means the whole family is going to
3 have to be enrolled, and so the out-of-pocket premium for that family to get that coverage would be
4 substantial relative to these other groups.

5 On the other hand, that last small wedge reflects quite large take-up from the previous slides, so that
6 this group is parents who are enrolled in ESI, so the marginal premium to move from self-only to families is
7 less for these and makes up 4.8 percent of the total.

8 So, the draft chapter you have has some additional detail about the range of premiums families
9 losing CHIP would face for job-based coverage. In the next session, there will be additional discussion of
10 affordability issues, not only with respect to premiums, but also for cost sharing, like deductibles and
11 copays, followed by sessions on the draft chapters on benefits and network adequacy. Obviously, all of
12 these issues have some interaction and we will bring them together tomorrow as we talk about potential
13 options for your consideration for the June report. But, for this session, we wanted to get your comments
14 on the draft chapter for March, so I'm happy to take any questions or comments you have.

15 COMMISSIONER HOYT: So, I had a couple of minor points that I sent you before in an e-mail,
16 but the biggest thought I had reading the chapter, thinking about the CHIP program potentially going away,
17 was, you know, I just thought of the COBRA program, where if you're not familiar with that, that's the offer
18 of insurance to people who have had it before, and then there, sometimes it's a dependent who loses
19 coverage. The experience of the COBRA price is capped at, I can't remember, it's, like, 104 or 108 percent
20 of the active employee premium. But, of course, the employer subsidy goes away, assuming there was one,
21 where the employer contributed something towards the cost of the insurance.

22 So, to the former employee or, in some cases, a dependent, there's sticker shock because now they're
23 being asked to pay the full cost and most people have no idea what their insurance actually costs. And, as

1 a result, the take-up rate is pretty low. Now, some of them moved on to other jobs, granted, and this isn't
2 a perfect analogy, but the COBRA experience is pretty bad from a loss ratio standpoint. It could be 200
3 percent to much higher than that.
4 So, I was just trying to think about the three different groups of kids outlined in the chapter and
5 what their experience might look like and what their impact on the risk pools would be. So, where you
6 have kids going into employer coverage or else to the exchange, it just strikes me as a pretty significant
7 financial hurdle from where they sit now, to join one of those two pools -- not in every case, but for a lot of
8 them, it would be pretty high and it, at least for an actuary, which is what I am, and, you know, all the health
9 plans and others will have them looking at this, I think the assumption is going to be they are going to
10 present above-average risk to the pool, and so my expectation would be this would negatively impact the
11 overall cost.
12 I don't know how the -- I'm assuming, I think, on the exchange rates, you've got separate kids rates,
13 so I would think you'd just see the kid rate outright go up. In the employer market, unless they've changed
14 it, there's no consistency at all in how premiums are set. It could be employee, employee-plus-one,
15 employee-plus-dependents. There's no kids rate, I don't think. So, there, it could be a little more hidden
16 in that you could actually have the -- you could actually see the overall price per person go down because
17 kids cost less than adults, but the overall risk has gone up, if you follow that.
18 And, then, I thought it might be appropriate to say something about the uninsured and their cost in
19 the chapter, no matter what they look like, whether these are really healthy kids or not so healthy. You've
20 got a million kids now, I would think, in many instances, going into the ER to get treatment for different
21 things, where, presumably, if they were in CHIP, they could have gone to a doctor's office or someplace
22 else. So, you're going to introduce additional cost into the system that wasn't there before and what are
23 hospitals supposed to do with that? There's no additional DSH money or anything else right now to help

1 cover those costs.

2 So, that's just some of the issues I thought about as we consider the possible end of the CHIP

3 program.

4 MR. PETERSON: And, on COBRA premiums, so there, people move to paying 100 percent of

5 the cost, actually plus some, and so, as you mentioned, they are going to select based on their expected

6 health care spending. What's different, I think, in this scenario -- in these scenarios is that you have

7 exchange subsidies for many families. If they are already entitled to the exchange credits for the parents,

8 then if they choose and enroll -- to enroll the children in the second-lowest-cost silver plan, then that may

9 have no additional premium for those families. And then, of course, if they move on the employer side

10 from single to family coverage, there are some marginal costs, but, generally, that will be subsidized

11 somewhat by the employer.

12 What's interesting is on that very last figure, where there was that small red wedge -- so, these are

13 parents who are enrolled in ESI but the kids remain uninsured -- the premiums for that wedge on median

14 were actually higher than for that orange group. In other words, that wedge of kids are parents for whom

15 the premiums would be extraordinary to move from self-only to family, and that may be because the

16 employer is offering no additional contribution toward that. The point being, the modeling takes all of

17 that into account, what premiums are going to be faced at the margin as they move from self-only to

18 one-plus-one, to family, and also take into account the health care spending that they are forcing for that

19 year that's going to affect some selection issues.

20 CHAIR ROWLAND: Chris, did the modeling take into account any effect from the individual

21 mandate?

22 MR. PETERSON: Yes, and, actually, that was a quite large effect, because in 2016, the individual

23 mandate will be in full effect --

1 CHAIR ROWLAND: Right.

2 MR. PETERSON: -- so, that'll be $695 per adult and half that for each child, unless the family is

3 exempt, and what those exemptions would be if CHIP were to end remains to be seen, but for now, they've

4 just modeled the fact that the individual mandate is as it is under current law.

5 CHAIR ROWLAND: Norma.

6 COMMISSIONER MARTINEZ ROGERS: So, I'm assuming that in Texas, because we have the

7 highest rate of uninsured children, that if they take CHIP away, we would continue to have even more at the

8 highest rate of uninsured children, because employer -- if the employer pays for your insurance, the rate for

9 families is much higher and most of the employers don't pick up that extra cost. So, it ends up being that

10 the kids don't get insured, only the employee.

11 COMMISSIONER MILLIGAN: I guess I wanted to pick up on Mark's question for a little bit. I

12 think I know the answer, but I just want to confirm what the answer is.

13 For most exchanges, the carriers have to file their rates late summer or early fall, typically at the

14 latest, for insurance commissioners to review the rates and get that all resolved in order to have the carrier --

15 qualified health plans listed on exchanges. I'm assuming that Urban's analysis did not incorporate any

16 effect on the rate filings this summer that would be part of what would be offered and available beginning in

17 January of 2016 because of uncertainty, which would have effects on prices and take-up and the amount of

18 subsidies and that sort of thing.

19 But, I just wanted to confirm that they're not making any exogenous assumptions about the effect

20 on rate filings of some of the CHIP authorization decisions to be made. Is that correct?

21 MR. PETERSON: I would -- I will double-check.

22 COMMISSIONER SZILAGYI: Two quick questions. I think you mentioned that these -- that

23 the Urban's modeling is based on premiums only and not deductibles or copays. That wasn't included in it,

1 and I was wondering how much the 1.1 million would change. What would the estimates change if

2 deductibles, copays are brought into the modeling?

3 MR. PETERSON: We can follow up on that, because I know expected health care spending is

4 taken into account and I don't know how much of the deductible and copayment policies are reflected in

5 the modeling. So, we can flesh that out a little more.

6 COMMISSIONER SZILAGYI: And my other question is, is there any information in the

7 modeling about the characteristics of the 1.1 million? So, would they look -- how much would this

8 exacerbate disparities? In addition to increasing the number of uninsured --

9 MR. PETERSON: Yeah --

10 COMMISSIONER SZILAGYI: -- would they be predominately minority, even more than the

11 current uninsured proportion --

12 MR. PETERSON: We haven't gotten to that level of detail as of yet. So, this is the first time that

13 we've presented these numbers just overall. But, I think those are the kinds of breakdowns that it's good

14 to hear what you're interested in so we can figure out what characteristics are of most interest, whether

15 that's race, ethnicity, and income groups.

16 COMMISSIONER SZILAGYI: And, potentially, age.

17 CHAIR ROWLAND: Because the CHIP children do look different than some of the Medicaid

18 children, as well.

19 Yvette, did you have a comment? Okay.

20 Thank you, Chris. So, again, please review the actual text in this section. If there are questions

21 that you think still need to be answered or explained about the numbers, let's get them clarified so that this

22 chapter can go forward.

23 And, I think, per these comments here today, I mean, we need to also put caveats on what it is that

1 the model has done and predicted and what some of the assumptions are, so that, I think, having a little
2 more of the methodology in the chapter would be very helpful. We know a model is only as good as the
3 assumptions into it and the data used for it.
4 We're going to turn now to part two of our work on the CHIP program, to a potential draft chapter
5 on looking at the issue that's already just been raised, the affordability of exchange coverage for children not
6 covered by CHIP, and here, we really do look at the cost sharing and the out-of-pocket payments that
7 would be incurred.
8 And, I think, as background here, one of the hard things that we have to grapple with is that while
9 we can look and say, oh, it would be more expensive for families to be in the exchange or other places, we
10 have not, nor have I seen many other places, established a standard for what level of cost sharing at what
11 income is sufficient or is inappropriate and a hamper. So, as we think through this chapter, let's very
12 carefully think through that issue along with kind of what we know about CHIP compared to the exchange
13 coverage, because, clearly, there are many who think more skin in the game is a better thing and there are
14 others who really raise that as a barrier to care, and we need to balance that out.
15 On that note, Joanne.
16 **### Session 2: DRAFT MARCH REPORT CHAPTER:AFFORDABILITY OF EXCHANGE**
17 **COVERAGE FOR CHILDREN NOW COVERED BY CHIP**
18 * MS. JEE: Thank you. So, this afternoon, Rob and I will be reviewing for you highlights from
19 draft chapter two on affordability of children's coverage. That's in Tab 3 of your meeting materials.
20 We just heard from Chris on how costs affect take-up of health coverage. This draft chapter looks
21 more closely at how premiums and cost sharing in CHIP and the exchange compare and updates analysis
22 that we presented at December's Commission meeting.
23 The draft chapter also provides some data on family expenses other than health coverage to provide

1 some context for understanding how their spending for health coverage fits in with their other financial
2 obligations, and that was in response to comments received last time.
3 Finally, the draft chapter, again, really focuses on CHIP and exchange coverage. Because of limits
4 on what data are available with respect to employer-sponsored insurance, we really weren't able to delve too
5 deeply into that analysis currently.
6 The chapter begins by describing the rules for cost sharing and premiums in both CHIP and the
7 exchanges. I'm not going to go into the details of those rules here today. They are outlined in your
8 chapter for you, and I know that most of you are familiar with those. I just wanted to highlight, though,
9 for you a few of the key points.
10 First, most states do charge premiums in their separate CHIP programs. That's important to
11 remember. In the context of what enrollees pay for premiums in the exchanges or their premium
12 contribution -- excuse me -- the premium contributions are determined as a percentage of their family
13 income and it is not really affected by the number of family members who are enrolled in their plan. The
14 family premium contribution is the maximum premium payment expected by the family before the premium
15 tax credit kicks in and begins to pick up the cost of the exchange plan or QHP premium.
16 And, just as a reminder, the tax credits are available to families on the exchange or individuals on the
17 exchange with incomes between 100 and 400 percent of the federal poverty level.
18 Third, the premium tax credits do not account for the cost of stand-alone dental coverage. Some
19 families will be purchasing stand-alone dental coverage to get coverage for -- dental coverage for their
20 children if the exchange plan or QHP doesn't provide the pediatric dental benefit and if the stand-alone
21 dental plan is available on the exchange.
22 And, lastly, the cost sharing reductions for the exchange plans do increase the actuarial value of the
23 silver tier exchange plans. But, despite those subsidies, the actuarial value of CHIP plans are still higher.

1 So, in other words, the cost sharing in exchange plans will be higher than it would be in CHIP.

2 * MR. NELB: Thanks, Joanne.

3 So, to help put together how these various complicated rules affect the average CHIP family,

4 MACPAC constructed a model to estimate the average costs that a family would pay for CHIP and

5 exchange coverage, looking at families with two children at 160 percent FPL and 210 percent FPL. As a

6 reminder, most families with children in CHIP are in this income range and most of those families, on

7 average, have about two children in their household. So, we did try to make sure this reflected the average

8 CHIP family.

9 The model looks at costs in a variety of ways, looking at the average premiums and cost sharing that

10 a family would face, and also looking at the total out-of-pocket maximum to get a sense of a family's

11 potential financial exposure.

12 Based on your feedback from the last meeting, we've added in dental premiums and we've also

13 looked at the family scenarios with a variety of different family circumstances, including whether or not a

14 child's parents are enrolled in the exchange.

15 The full results of our analysis are in your materials. The chart is on page ten of the draft chapter.

16 And, I'm happy to answer any questions about the specifics. But, in the interest of time, I just thought I

17 would highlight some of the key findings about how exchange costs compare to CHIP and how it compares

18 to family income.

19 So, first, in terms of premiums, we found that children with parents enrolled in exchange coverage

20 will have little or no change in their premium costs because many of those families will already be paying

21 their maximum premium contribution for parent-only coverage. This was true for both the two-parent

22 and single-parent families studied. However, if a child's parents are not enrolled in an exchange plan, then

23 a family's premium contribution for children's coverage will be six to 11 times higher than CHIP in the

1 examples studied, depending on family income.

2 As a percent of family income, the premium costs in this example are about 5.2 percent of family

3 income at 160 percent FPL, and 7.2 percent of family income at 210 percent FPL.

4 Now, regardless of family composition, as Joanne mentioned, most families wanting to obtain

5 pediatric dental coverage will face additional premium costs because pediatric dental coverage isn't included

6 in their regular exchange plan. In 2015, about two-thirds of second-lowest silver plans didn't include

7 pediatric dental coverage, meaning that those families would need to pay extra to obtain that care for their

8 children.

9 Second, in terms of cost sharing, we found that the costs of exchange coverage are consistently

10 higher than CHIP, regardless of family composition. Again, this is all looking at the second lowest silver

11 plan after the cost-sharing reductions are applied.

12 Average cost sharing in these plans is about 7 to 15 times higher than CHIP in the examples studied,

13 which again varies by family income.

14 In addition to this higher cost sharing, on average, there's also higher out-of-pocket cost-sharing

15 maximums for these families. We found that exchange cost-sharing maximums were 6.6 percent of family

16 income at 160 percent FPL and 13.3 percent of family income at 210 percent of FPL.

17 In contrast, as I am sure you're aware, in CHIP the statutory limit for cost sharing and premiums is 5

18 percent of family income. In practice, many CHIP programs have limits that are much lower than that,

19 averaging about 2 percent of family income.

20 So putting this all together, what's the overall effect on families?

21 First, we found that the total average cost, that is average premiums and average cost sharing, is

22 more than twice that of CHIP in the exchange if a child's parents are enrolled in exchange coverage and are

23 more than seven times that of CHIP if the child's parents are not enrolled in exchange coverage, again,

1 based on the examples studied.

2 Second, we found that the total potential financial exposure, that is, the premiums plus the
3 out-of-pocket cost-sharing maxes, are, again, much higher than CHIP, and they could exceed 11.8 percent
4 of family income at 160 percent FPL and 20.5 percent of family income at 210 percent FPL.

5 Now, while the costs of exchange coverage for children are high, it's important to note that it may
6 actually cost less than available employer-sponsored coverage for some families. As Chris noted, there isn't
7 very good data to compare employer-sponsored coverage to the exchange, but some of the preliminary data
8 collected from Urban suggests that the premiums for some families may be higher than the exchange.

9 So now I will turn it over to Joanne to outline some potential policy approaches to address
10 affordability.

11 MS. JEE: Great. Thanks.

12 So following the family examples, the draft chapter describes some possible approaches for
13 addressing affordability of children's coverage. The conversation on these approaches really began, again,
14 at the last meeting but is ongoing.

15 The draft chapter lays out some key design questions, including ones we put before you last time,
16 such as whether to approach affordability from the angle of premiums or cost sharing or both and which
17 population of children within the CHIP income range would those target approaches, some of them or all
18 of them, and what balance should be struck between enrollee contributions to premiums and cost sharing to
19 purchase their coverage and the subsidies that are so helpful to them and allow them to purchase the
20 coverage.

21 The draft chapter describes some policy options that the Commission may want to consider, such as
22 augmenting existing exchange subsidies, and that would be the premium tax credits and the cost-sharing
23 reductions, which I forgot to mention before but just wanted to remind you are available to those with

1 incomes between 100 and 250 percent of the federal poverty level, currently.

2 Providing wraparound coverage may also be an option or an approach to consider, and again, that

3 could occur on both the premium and the cost-sharing sides.

4 Finally, the draft chapter asks whether there are other alternatives the Commission might want to

5 consider, such as an expansion of Medicaid coverage to some or all of these children, up to some set income

6 level.

7 The Commission's work to assess these options will continue over the course of this and future

8 meetings. In the meantime, though, Commissioners, if there are any comments on the draft chapter that

9 you would offer, we would appreciate them.

10 COMMISSIONER CARTE: Thank you, Joanne and Rob. There is a lot of helpful information

11 in this chapter, and I think the question of cost sharing in the exchanges is a really important one. I think

12 that families are pretty sensitive to cost sharing, and I think an important piece of information that you

13 provided in that chapter is that that's found in Box 1 where it talks about the percentage of family income

14 that remains disposable income for a family of -- what is it? Three, Rob, or four?

15 MR. NELB: Average example. Yeah, about three. It's about 10 percent of family income.

16 COMMISSIONER CARTE: Right. And that 90 percent of that family's income basically is

17 going to go towards their basic cost of living, like housing, transportation, and food, clothing. So they

18 really only have about 10 percent remaining, and I think that that's -- well, aside from the federal regulation,

19 I think that's why CHIP programs have had a modest amount of cost sharing.

20 So I can't really see how the Commission cannot look at the consideration of some cost-sharing

21 limitation related to CHIP programs overall.

22 Also, Peter, I thought you were right on line with your question about how much cost sharing in

23 addition to premium costs would affect the number of uninsured, and I don't think that the model that

1 Chris presented ultimately took that into effect.

2 Of course, another way to look at some of these issues would be to -- that we may discuss when we

3 get into the next chapter would also just be to look at a certain level of actuarial value, and as a CHIP

4 director, we have used copayments. I think copayments can be an important form of cost sharing,

5 particularly when you want to steer consumer behavior; for example, purchase of a generic.

6 But I really have problems with cost sharing like deductibles. I think there's a comment in one of

7 the chapters that says that cost sharing sometimes can be designed to really present an access barrier. As a

8 staff person commented this morning, we're a payment and access commission, and you can have coverage,

9 but if you don't have access, then what good is it?

10 I think those are the things I hope we consider.

11 COMMISSIONER GABOW: Thanks for putting Box 1 in. I like that.

12 I have a couple questions on Box 1. What year is this data from?

13 MR. NELB: It is from the 2013 --

14 COMMISSIONER GABOW: 2013.

15 MR. NELB: -- Consumer Expenditure Survey.

16 COMMISSIONER GABOW: And is it possible to do it for the same groups that were doing the

17 coverage for 160 with two children?

18 MR. NELB: We are looking into it and can get back to you.

19 COMMISSIONER GABOW: I think that would be good if we can put that in and then have

20 what the total cost sharing might be.

21 EXECUTIVE DIRECTOR SCHWARTZ: We would like to be able to do it, and we're barking up

22 several different trees to figure out how we can get it.

23 COMMISSIONER GABOW: The other comment I would just make in Box 1, which again I

1 want to emphasize how grateful I am that you put that in, is that education -- there are growing fees for kids
2 for all sorts of things in schools, and so I think maybe it's not luxury education. These are fees for things
3 that have to be paid if the kid is going to be in school, including some districts I think are charging for
4 transportation. So I am emphasizing those aren't optional, many of these educational -- that was sort of
5 one way around of saying that.
6 My two other comments are, could you elaborate on who would be providing the wraparound
7 coverage? What is embedded in that phrase? That's one question.
8 Then the final one, which of those three options is the simplest, administratively? Well, expanding
9 Medicaid may be the simplest.
10 MS. JEE: I think on who provides the wraparound, in my mind that's still a bit of an open
11 question, and I actually think that that's something that, as we develop the options further and hear more
12 from you on sort of how you might want to approach the affordability question is something that we could
13 sort of develop further.
14 I'm sorry. What was the second question?
15 COMMISSIONER GABOW: That it's hard to imagine that any entity doing wraparound is going
16 to be simple because there will be a coordination of benefits. There will be additional complexities. So
17 not only who and how, but its complexity would be worth teasing out.
18 MS. JEE: Yeah. The complexity point is well taken, and the chapter does begin to talk about that
19 a little bit, and we did discuss it at the previous meeting at well.
20 CHAIR ROWLAND: As you look back at your Figure 1, there's clearly a big difference between
21 parents who are in the exchange with children and using the exchange without a parent being enrolled.
22 Can you explain a little bit about what's going on there? But does that lead to thinking about are there
23 different options we should consider for when a family is covered in the exchange and when it's not?

1 MR. NELB: Sure. We can definitely add more about that. There's sort of two types of
2 scenarios. One is where the parent is actually not eligible for the exchange but the child is. So a parent
3 who is not a citizen or a parent who has an offer for self-only coverage, they are probably about 10 percent
4 or less than the CHIP population.

5 Then there is a portion where the parents are eligible but not enrolled in exchange coverage, which
6 is another subset to consider.

7 CHAIR ROWLAND: But why is the cost so much higher?

8 COMMISSIONER ROSENBAUM: I think we are looking at -- the difference between -- and that
9 was going to be my point. In CHIP, we are not really looking at premiums. We are looking at a monthly
10 enrollment fee, because Congress made a very important decision, which I think we have to be very clear
11 about, that families should not be exposed to the full force of a premium.

12 In child-only coverage in the exchange, what we're looking at is the effect of modified community
13 rating; that is, the child is really paying a premium. When the family already has the coverage, then adding
14 the child is not a cost.

15 When you have to go into a market of modified community rating and buy a child's policy, you're
16 inevitably -- that's the point of modified community rating, and one of the questions is, overall, do we gain
17 enough from bringing children into the exchange, so that it justifies subsidizing the child's premium to a
18 much greater degree than we do because of the benefit of a broader pool.

19 We have talked about this before. One of the questions I keep coming back to in my own mind is
20 -- and this is all downstream stuff. We're not talking about the next two years when continuing CHIP
21 funding is absolutely essential, because working this through is such -- you know, it's complicated.

22 But what we really need to know is whether the beneficial effects of having a more unified pool are
23 such that it justifies helping families a lot more with the cost of their coverage and not exposing them to a

1 premium, and we have to be clear that in CHIP, we're not exposing families to premiums. We're having
2 them pay enrollment fees, which is as it should be, given Box 1. They can't possibly afford a premium.
3 So my suggestion for the chapter is that we get sharper on our language and we really lay out for
4 Congress what the fundamental policy choice is. It's not apples to apples. It's two entirely different
5 financing models, and the crucial question of whether it makes sense in the long run to move toward unified
6 financing is something that we can answer only by understanding what somebody like Mark, with those
7 skills, could tell us, whether you gain enough from a bigger pool with younger people in it to then in turn
8 make sure that families are not made worse off.
9 CHAIR ROWLAND: But I think we also have to really deal with this who is in the exchange,
10 whether the parents are or not, because there may be two very different policy solutions. If it's a
11 child-only, you may have to come up not with a wraparound plan, but with an alternative plan.
12 COMMISSIONER ROSENBAUM: Exactly.
13 CHAIR ROWLAND: Okay. Then I have Chuck, and I have Trish, and then I have Sharon.
14 COMMISSIONER MILLIGAN: So apart from the context of CHIP, there have been a lot of
15 concerns going back to the rollout of a lot of the exchange products, that cost sharing was going to be
16 unaffordable for low-income families, and that the out-of-pocket data that you've identified might lead to
17 affordability challenges even for families below 250 percent of poverty, apart from the CHIP-related issues.
18 So I think it would be helpful to monitor, and the data and information may not come timely for the
19 chapter. But I think we're going to be learning soon the extent to which families dropped coverage from
20 the first enrollment year to the second enrollment year related to their experience of the affordability of cost
21 sharing, and I think that will help inform this affordability question we're talking about for families below
22 250 percent of poverty.
23 In other words, if the hypothesis is that it's unaffordable, given what's in Box 1, I think what we're

1 going to see is families dropping out in the second year in QHPs below 250 percent of poverty, apart from
2 CHIP, and I think whether that hypothesis proves to be true or not, it will be helpful to know as some of
3 the early qualitative and quantitative data comes out.
4 CHAIR ROWLAND: Trish.
5 COMMISSIONER RILEY: It seems to me there's another cut at this analysis when we think
6 through our options, and that is who pays, and so we need to think about, I would assume, states when they
7 see the end of CHIP would no longer budget any money for children. And so, as a result, the Medicaid
8 expansion creates a cost to the states that we need to talk about. Subsidies would create a cost to the
9 federal government. Would we anticipate a continued role for the states in funding some portion of this
10 expanded coverage, and how feasible is that? So I think there's a whole series of not just is it affordable,
11 but who pays from the federal and state perspective.
12 CHAIR ROWLAND: Okay. Sharon.
13 COMMISSIONER CARTE: I really had meant to include earlier in my comments that there's
14 another side also to cost sharing when it reaches that tipping point. I was mentioning it to Yvette this
15 morning. I think we've both seen families at these low-income levels struggle to deal with cost sharing.
16 When they reach that point and you look at these income levels, it's not hard to imagine that with a sick
17 child, it has an ongoing chronic care need. That at a certain point, that parent has to weigh the option
18 when do I cut my hours back, so that I qualify for Medicaid. One parent stops working, so they qualify for
19 Medicaid. So I think it's also possible that we set up a disincentive for these working families to take
20 advantage of QHPs and stay working.
21 CHAIR ROWLAND: Andy.
22 COMMISSIONER COHEN: I just wanted to follow up actually on a point that I think Sharon
23 has made a couple of times today and then see if we can maybe beef up the chapter a little bit with evidence

1 that may not exist, so I'm asking.

2 And that is, we make a lot of assumptions in sort of talking about the value of health coverage and
3 the burden on families of unaffordable premiums, cost-sharing premiums and cost sharing, although we
4 haven't quite defined it. But I thought it would enhance the chapter and kind of remind us all a bit about
5 what it's all about, if there was a little bit more evidence, if it exists, about this sort of low-income family sort
6 of sensitivity to cost sharing and how it actually affects their behavior in terms of seeking care for their kids,
7 because I feel like it's all sort of implicit in what we're talking about, but to the extent that there is any
8 literature on that, like what is the decision tree, what are the sort of impacts on knowing you're going to
9 have a $50 copay and sort of being like is this fever really a big deal or whatever.

10 And for different kinds of kids, obviously the scenario is quite different, whether it's a kid with a
11 chronic condition or just something acute that in an adult actually wouldn't necessarily be that big of a deal.
12 But if there was no cost-sharing barrier or very low cost-sharing barrier, someone would go to the doctor,
13 and it might be more serious in a child.

14 So I think a little bit more connection to sort of like outcomes and clinical impacts of having high
15 cost sharing and whether that affects a family's behavior in seeking care in a way that we -- there are some
16 studies about this in the adult population. Some care that you don't get, cost sharing is higher might be
17 appropriate, and some is inappropriate. In some ways, the risks for that is higher for children, but some
18 review of that literature, I think would really be important and bring us back down to sort of the really
19 critical point that's implicit, but are kids going to get the right, appropriate care or avoid care they should be
20 getting if cost sharing is substantially higher, sort of on a per-service basis.

21 CHAIR ROWLAND: Donna.

22 COMMISSIONER CHECKETT: I think it belongs in this chapter, although possibly in the
23 benefits chapter as well, but the concern being families who are purchasing an exchange product for a child

1 and their -- because of the Box 1, which, of course, no one in the audience really knows what is in Box 1,
2 and I am sure they can hardly wait to find out when the chapter comes out.
3 [Laughter.]
4 COMMISSIONER CHECKETT: It's totally embargoed until then, though. But, seriously, the
5 incentives for a family to be picking a catastrophic product, and I'm sitting here thinking and I thought I
6 guess, you know, the age rule that -- because these are kids, so they can buy the catastrophic product, which
7 I think is very cheap coverage, and if I were really strapped, that would be the one I would pick. It's also
8 the one where you really have significant, significant risks if indeed there is some type of catastrophic event.
9 So maybe pulling that out and teasing out the incentive on it to buy a very low cost premium product and
10 then the risk that that puts the family in.
11 CHAIR ROWLAND: And I'm going to ask that we tip our hat a little bit, and can you explain to
12 the audience what's in Box 1?
13 MR. NELB: Sure. So based on feedback from the Commission to kind of get a sense about the
14 overall costs for low-income families, we looked at the Consumer Expenditure Survey for 2013, and using
15 the data that was available, looked at low-income families that are in the CHIP income range and what their
16 income and expenses are. These families sort of in aggregate data, which we're going to, you know, think
17 about, but the bottom line I guess is that most of these families -- their expenses actually exceed their
18 income, exceed their after-tax income. But about 90 percent of their income goes towards housing,
19 transportation, food, and clothing. So there's not as much left for health, education, entertainment, or any
20 other sort of daily living extra expenses.
21 CHAIR ROWLAND: And this is part of what the Commission is trying to make sure that when
22 we talk about low-income populations, we're being realistic about what their overall ability is to afford care.
23 And I think even in the context of this chapter, it's also important to separate out premiums from cost

1 sharing, because I don't actually consider them -- they both contribute to out-of-pocket burdens, but a
2 premium is something that a family has to pay every month whether they use services or not, and also that if
3 they stop paying it, they lose their access to the services. Yet I know in much of the work that others have
4 done, families don't always understand even what they're getting for a premium or the concept of premiums.
5 We've seen with the rollout of the Affordable Care Act just a lack of understanding about what health
6 insurance generally even is and how it works.

7 So I think we need to be sensitive to that, and then to the cost-sharing side, that's especially
8 important when we think about the fact that the burden of illness is not distributed the same, and so certain
9 families are going to face far, far higher levels of cost sharing and other families that may not use as many
10 services won't. So I think we need to note within this that there's no such thing as a typical person.

11 COMMISSIONER GABOW: The other thing about expense isn't captured, I don't think, in the
12 information in Box 1 about what is housing and transportation, is that in every family things happen. You
13 know, your car breaks down. You blow a tire. You know, your refrigerator goes on the blink. And so I
14 think some -- there may be absolutely no data on what sort of crisis expenditures are for the average family,
15 but my guess is that, given the kind of cars they buy, houses they live in, et cetera, they have a fair amount of
16 this. I know when I was CEO at Denver Health, I would get e-mails from employees about this: "Is
17 there any way you can advance my salary because my roof caved in in the snowstorm?" Or, "My car broke
18 down, and I can't get to work."

19 So I think sort of painting a realistic picture of there probably is actually zero disposable income at
20 this level when you think about things like that. So maybe it's a qualitative statement rather than a
21 quantitative one, but it's probably worth pointing it out.

22 CHAIR ROWLAND: A number of years ago, we tried to collect some of the family budget
23 information and found that most families spent more on their budget than they did bringing in their

1 income, so that they were basically living in a deficit situation. And as you said, there was no cushion for
2 any loss of some car or any other unexpected event.
3 There's a group from Missouri that used to do an incredible scenario of they would give people a
4 fixed -- it was a kind of game, but they would give people a fixed amount of money, and then make them
5 live through trying to balance that amount of money, and you draw different cards, and your card would say,
6 "Your car broke down this week, but you still have to pay your mortgage," and then the collector would
7 come. And I think the reality of living on the edge of no income is one that we always have to keep in
8 mind as we go forward with this work.
9 COMMISSIONER MARTINEZ ROGERS: Just one comment, going along with what you were
10 saying, Diane, is that is there any way that we -- and maybe there isn't, but that we could talk about the lack
11 of education that most of the public has towards what is the best policy? I think what Donna said or
12 someone said is very true, that they go for the cheapest because they're looking at their children, and they
13 say, "Well, they're healthy, they're pretty healthy, they're not sick." You know, "They're not going to get
14 sick because they've been healthy for seven years. Why would they be unhealthy?" And so they go with
15 the cheapest plan, not looking at what if this happens.
16 You know, so I think lack of education and public consumer education is -- if there is a way to
17 include it, I would love to see something there.
18 CHAIR ROWLAND: You know, I think, Norma, you've raised a really good point in terms of
19 recommendations, thinking about what counseling needs to happen to individuals. One of the things
20 we've really seen with the Affordable Care Act is just how ill informed many of the purchasers of these
21 health plans are because they have not had a lot of experience with that, and that is probably another piece
22 we should always keep in mind as we go forward.
23 Other comments on this section?

1 COMMISSIONER ROSENBAUM: I want to go back actually to the point you made before and
2 make sure that we are really clear, because it's going to be so important for the -- this chapter is so very
3 important for Congress, that we're looking at the question of how generous Congress should be in helping
4 families afford coverage for their children. And even though Congress may decide that where adults are
5 concerned, the subsidy levels are going to be somewhat less, the most important thing about CHIP, in my
6 view, is that Congress made a very fundamental decision many years ago to be much more generous than a
7 standard premium subsidy system as we now know it would allow, and that it's perfectly plausible, looking
8 down the road, to end up with a unified system where, in fact, the subsidy is more generous for children,
9 even in a family arrangement. I mean, it's not an apples or oranges, either you're generous for children and
10 you keep them out or you're not generous for children and you put them in. There is a way to combine
11 the policy decision represented by CHIP with the policy decision of making it possible for families to afford
12 coverage entirely. Okay? You can be somewhat more generous with the dependent component of the
13 subsidy package. That's all. So that Congress is not left with the feeling that we're saying either you're
14 going to have a pediatric policy that works or you're going to have a policy of less generosity but, you know,
15 families. We need to convey that you can chew gum and walk at the same time here.
16 COMMISSIONER CRUZ: Yeah, I think that the chapter could benefit also from some historical
17 perspective of how difficult it has been for many states to enroll children in CHIP, especially children from
18 some underserved groups and racial and ethnic minorities, because once they have done all this work, then
19 the parents are going to think someone pulled the rug from under their feet, and now they have to start all
20 over again. So it's going to be a real lot of work for the states to be able to shift these children into other
21 programs and offer them viable alternatives.
22 CHAIR ROWLAND: Okay.
23 COMMISSIONER HOYT: We talked before about the phenomenon that individuals or families

1 are going to have income that fluctuates and so they'll move potentially from Medicaid up on to an
2 exchange or in and out of Medicaid, and with CHIP being gone, we -- this may be obvious to us, but I guess
3 I'm wondering if it's obvious to others who will read the report. Would it be helpful to do an example of a
4 kid who's at a hundred -- in a state that's expanded to 130 percent of FPL? What is the cost sharing and
5 premiums in Medicaid? What percentage of their income is that individual or family spending? Because
6 this is more like a chasm or just an enormous hurdle to go over when you jump from being in Medicaid to
7 go up to one of these other alternatives that we're outlining in the report. And I think that's the shock and
8 awe that we're kind of talking about, but it might help drive the point home.
9 COMMISSIONER MILLIGAN: I wanted to come back to Sara's "walk and chew gum" comment
10 for a second, too. I think that when we talk about the policy approaches on the final slide, one that occurs
11 to me based on Sara's comment is that the cost-sharing subsidies below 250 percent of poverty could be
12 targeted to children, which is -- it violates the ease of administration principle. But there are other
13 examples where preventive care cost sharing is different from other service cost sharing in lots of federal
14 law. So I do think that that -- and I'm not offering an opinion about it, but I think it's an option that
15 should be presented as such.
16 CHAIR ROWLAND: I think the range of options that we should lay out are much broader than
17 the ones we started with, and I think we started to just lay out some issues for consideration. I don't know
18 even if we should call them "options," "potential approaches" to address some of the concerns. "Options"
19 sounds like we're going to pick one right away.
20 Okay. Thank you. Good chapter. Lots of work to go, but good chapter. And I do like Mark's
21 point that I think as the Commission on Medicaid and CHIP, we should always remind people of where the
22 Medicaid program is and where those children that are enrolled in Medicaid are getting their coverage and
23 what their levels are, so that that point is there.

1 We're now going to move from looking at the financing and affordability side to looking at the
2 scope of benefits in CHIP compared to other sources of coverage. And so Ben is going to lay out some of
3 the follow-up analysis to our earlier discussion.
4 ### Session 3: DRAFT MARCH REPORT CHAPTER: COMPARING CHIP BENEFITS TO
5 OTHER SOURCES OF COVERAGE
6 * MR. FINDER: Thank you. This chapter is a continuation of our work in CHIP benefits that
7 started with the development of the June 2014 chapter. In particular, the presentation draws from the
8 October meeting in which we presented the additional findings or additional benefits comparison analyses.
9 From these analyses, we found that most major medical benefits are covered by all sources of
10 coverage. Some benefits are covered by some sources but not others, for example, dental services -- Rob
11 and Joanne talked about that a little bit -- are required to be offered in CHIP programs, but they are not
12 required if stand-alone dental plans are offered in exchange plans.
13 Benefit comparisons are inherently complex, and the chapter includes a discussion of some of
14 limitations of this work. And the chapter concludes with a discussion of the policy options that have been
15 raised by researchers and others to address concerns about the comparison of benefits, comparability of
16 benefits.
17 The chapter begins with a brief description and discussion of health benefit coverage in CHIP,
18 Medicaid, exchange plans, and employer-sponsored insurance plans, and before I dive into this, I should
19 note that when we talk about CHIP benefits, we're really talking about the benefits offered by separate
20 CHIP programs. The children that are enrolled in Medicaid expansion CHIP programs receive the
21 Medicaid benefits, including EPSDT benefits, which I'll mention in just a minute.
22 So now to dive in, the states have flexibility in separate CHIP benefit design. This leads to a
23 variation in the benefits that each state includes in their CHIP coverage. Medicaid benefits generally

1 follow a dichotomy of mandatory and optional benefits, and for optional benefits, some services are
2 covered widely and others less so.
3 Medicaid programs are required to cover Early and Periodic Screening, Diagnostic, and Treatment
4 benefits, which are also known as EPSDT benefits, for children under 21; and this means that children's
5 coverage in Medicaid may expand to include services not listed under the state plan.
6 Exchange plans are required to cover the ten essential health benefits, and the regulations defer to
7 states to define what services may be available under these broad benefit categories. And although it is one
8 of the ten essential health benefits, exchange plans are not required to include pediatric dental if stand-alone
9 dental coverage is available in an exchange.
10 Employer-sponsored insurance is highly variable. It's generally designed by employers and insurers
11 with employee benefits -- employee health needs, rather, and costs in mind. There are few federally
12 mandated benefits, and some mandates may not apply to self-funded or self-insured plans.
13 The chapter draws some comparisons about CHIP to other sources of coverage. As I mentioned
14 before, most major medical services are covered by all sources of coverage. For example, inpatient and
15 outpatient hospital services, physician services, and prescription drug services are available in CHIP,
16 Medicaid, exchange plans, and employer-sponsored insurance coverage.
17 For other benefits, coverage varies. Dental benefits are available in CHIP and Medicaid, but plans
18 are not required to include pediatric dental coverage in the exchange if stand-alone coverage is available.
19 Furthermore, premium subsidies may not take into account the additional cost of stand-alone dental plans,
20 so some families might incur additional premiums with pediatric dental coverage in exchanges and
21 employer-sponsored insurance. There is also no requirement that families buy such coverage except for a
22 few states, namely, Kentucky, Nevada, and Washington.
23 The chapter also notes that coverage varies for other benefits like autism services, including applied

1 behavioral analysis therapy, audiology exams, and hearing aids.

2 And variability of covered benefits within a source makes it difficult to compare across coverage
3 sources, so take autism benefits, for example. If you're a kid in the 82 percent of CHIP programs that
4 offer some coverage, you might be better off than a child in the 77 percent of states that cover this in
5 exchange plans. But there are still 18 percent of CHIP programs that don't offer this coverage. So while
6 there's maybe some advantages to having CHIP, that picture isn't completely clear.

7 So these comparisons should be interpreted with some caution because benefit comparisons can be
8 complicated by different factors, and the chapter goes into depth describing three of these factors.

9 First, the comparisons that we have made are at the category level and, therefore, lack some
10 specificity that would be useful in making comparisons across sources of coverage. Autism services, for
11 example. The range of services used to treat autism is broad and can include physical, occupational, and
12 speech therapies, as well as other services. But the data sources do not provide specificity on what services
13 are included under the broad category definition of autism services.

14 Second, the comparisons drawn in the chapter are made without respect to the scope of coverage,
15 so even though a benefit is offered, we don't know how much and what type of services people can receive.
16 Most often this applies to benefit limits, and what that means is that although a service may be covered, we
17 don't know or we're not sure how much of the coverage a person can receive under that benefit.

18 And, finally, all of these sources of coverage have the ability to limit or expand services when
19 services are determined medically necessary. One example of how medical necessity might limit access is
20 that a plan can require that a physician prescribe physical therapy before someone becomes eligible for
21 services. On the other hand, someone could exhaust a benefit limit and appeal for more services based on
22 a determination of medical necessity.

23 As I mentioned earlier, the chapter concludes with a discussion of the policy options that have been

1 raised by researchers and others to address concerns about the overlap, about the comparability of benefits.
2 The options are broad and may have some overlap with some of the other chapters we're discussing today,
3 and I think we'll discuss these more tomorrow, although I'll be glad to take any comments that you might
4 have on the options or the chapter now.
5 Thank you.
6 CHAIR ROWLAND: Thank you, Ben. Patty?
7 COMMISSIONER GABOW: Thanks for clarifying that this is CHIP expansion. I think that has
8 to be clearer in the chapter.
9 My comments fall into two sort of big buckets. One is I realize you're working with mean
10 comparisons, but that makes it really hard, I think, to understand what it means for an individual. If it's
11 possible, which it may not be, to take several representative states and do, like we've done before, a real
12 example -- this is Suzie Smith in Colorado. CHIP ends. She goes to this. Here is what would be the
13 options in the exchange coverage. Because there's so much variability in all these things that you
14 mentioned, the category is covered, so what does it really mean?
15 So to get granular with a couple examples, I think would really be useful, if that's feasible.
16 CHAIR ROWLAND: But was not one of our conclusions previously that there was not a huge
17 amount of variation, except around a few specific benefits?
18 MR. FINDER: Yeah, that's right.
19 COMMISSIONER GABOW: Well, that's unclear from what is there because there's not a lot of
20 variability in the categorical coverage, but the implication when you go through how many visits you can
21 have or other details, it sounds like there is a lot more variability than the overall percentage of category.
22 If that's not true, then these three other factors that you listed are only minimally relevant, but if
23 they are actually relevant, then I think a more granular example would be useful.

1 And then I thought what really was being presented were just three major options. One, you could
2 have a federal option with the Secretary changing EHB for children. You could have a state option where
3 they were permitted and/or required to change it, or you could have a requirement to include certain
4 services in all exchange plans, either by increasing the subsidy or actually mandating that they be in.
5 But are there really just three options? For example, I always – wrap-arounds create problems, but
6 what about Medicaid as a wrap-around or some other options?
7 I think we may have just too few options there, and I think maybe a little bit more of the pros and
8 cons of each option would be -- or maybe not option, but alternatives would be good. But overall, I think
9 this is a good beginning. Thanks for doing it.
10 CHAIR ROWLAND: Great. Chuck and then Sara.
11 COMMISSIONER MILLIGAN: So the way I think this could be read is that we neglect the
12 threshold question about whether comparability of benefits ought to be addressed and whether that change
13 in benefits related to a CHIP transition is something that merits a recommendation down the road, and then
14 the second-level question is, if so, what is that recommendation? So I think we need to be pretty explicit
15 about that threshold question, which I don't think -- I mean, when I look at the slides, it looks like
16 something -- one of these approaches should be taken, and if so, which one? I think we need to do a
17 better job of addressing that threshold question first.
18 CHAIR ROWLAND: Sara and then Gustavo.
19 COMMISSIONER ROSENBAUM: Just a couple of things. First of all, I think we may be
20 overstating the -- and I'm not sure how central it is to the chapter, but I think we are overstating the extent
21 to which we're as much at sea about employer benefits as the chapter implies, simply because the essential
22 health benefit statute itself is modeled on the typical employer health plan, and we know from the IOM
23 study that with the exception of habilitation services -- and interestingly, pediatrics is a special subcategory --

1 everything else we see in the essential health benefit statute is pretty standard in employer coverage.

2 So I think we can note that we don't know with precision, but we don't know with precision about

3 any of this coverage stuff. I have spent more years of my life trying to figure out what's covered probably

4 than I should have, and it's an unknowable thing until you are really in a contractual battle with a plan over

5 what's covered. You don't know what's covered. But that's one thing.

6 The other thing is I think it's important that we point out that an important decision was not made

7 for CHIP, perhaps because Congress had just in fact reauthorized CHIP, perhaps because Congress was not

8 sure what it was going to do with CHIP. So a decision was not made in CHIP that was made with

9 Medicaid, which was for the newly eligible Medicaid beneficiaries who were going to be covered by

10 benchmark plans, Congress brought the benchmark up to the essential health benefit statute level. And

11 Congress did not do that with CHIP.

12 Now, at any given moment in time, a lot of CHIP plans may in fact cover what's covered in an

13 essential health benefit package, but they don't have to, and if the money starts to run out and become tight,

14 then rather than take benefits away entirely from children, you may start to thin out your benefit plan.

15 I think we ought to draw Congress' attention to the fact that the framework that was introduced for

16 Medicaid alternative benefit plans was not introduced into CHIP, and there really are substantial statutory

17 differences between the CHIP benchmark, as required by law, and the Medicaid alternative benefit plan

18 benchmark, as required by law. How those things play out as a practical matter, you can shed some light

19 on with a whole bunch of caveats, but to the extent that Congress has decided or will decide to continue

20 CHIP as a separate program for some considerable length of time because it's not sure what it's going to do

21 with the broader question of subsidized coverage, I think a fair question becomes whether in fact, as a

22 framing issue, we don't do the same thing in CHIP that we did in Medicaid. And if in fact CHIP coverage

23 is very good, it should not make any real cost difference because the services are already being covered, but

1 it doesn't put a floor underneath it. It's at least equivalent to the Medicaid alternative benefit plan package.

2 COMMISSIONER CRUZ: Yes. I have a quick question. On Table 1A under pediatric dental,

3 you have under Medicaid only 94 percent of states that actually covered those services, but this is mandated

4 under EPSDT. Why do you have --

5 MR. FINDER: I think in some of the notes and the table, it makes clear that EPSDT benefits are

6 required to be provided.

7 It's possible that it's not listed in some state plans but is provided under the EPSDT benefit. I

8 think this speaks to the issue of how benefit categories really limit our analysis or limit our ability to better

9 analyze these services.

10 COMMISSIONER ROSENBAUM: It's an artifice of the language, regardless of whether it's

11 covered under the plan. They cover it, but it's not in the plan.

12 COMMISSIONER CRUZ: Yeah.

13 EXECUTIVE DIRECTOR SCHWARTZ: I just wanted to ask a question before Ben leaves. I

14 mean, we're not done with this issue, regardless of what you put in this chapter. We'll talk about it more

15 tomorrow and more in the months ahead.

16 To Chuck's comment on where you want to leave things in this chapter, it would be helpful for staff

17 to hear that. I think on the two previous chapters, despite the vagaries of the analysis, the fact that it's

18 money makes it a little bit more clearer than here. And I would like to hear a little bit more about what

19 you think the message of the chapter is, because that would help us in sort of finishing up this chapter, even

20 if you haven't decided what more you want to do. The chapter clearly is at a point where you're -- more

21 work to be done, but I think some feedback on that would be helpful.

22 CHAIR ROWLAND: Sharon and then Donna.

23 COMMISSIONER CARTE: Well, I think others really have indirectly pointed out the message in

1 this chapter, it really is to be found in the fine print and in the careful reading about things like medical
2 necessity and other limitations and what Sara was saying. You really don't know what that plan covers till
3 you need it.

4 Of course, I know, I realize I'm coming from the lens that with CHIP children who have substantial
5 coverage and they access the needed services for the most part when needed.

6 Again, I don't see how we can't ultimately get away from looking at a recommendation towards a
7 child-centered benefit and one that again goes more according to what CHIP -- recall that in the early days
8 that CHIP was very scrutinized and questioned because it did not have the full EPSDT benefit, but really
9 we see that it does offer substantial coverage. It is able to meet children's needs, by and large, except for
10 maybe the severely disabled.

11 I would hope that we perhaps could indicate in this chapter that it needs to be looked at further and
12 reviewed closely, with an eye to recommending what would sustain a robust benefit.

13 CHAIR ROWLAND: Donna, then Peter, then Chuck.

14 COMMISSIONER CHECKETT: When I look at the chapters are a group, I think we're
15 continuing our work on CHIP, and we're leading off very nicely with just the question about what is going
16 to happen if CHIP runs out and it's not extended. Then we really move into the cost, the cost to the
17 parents or caretakers as really kind of the first part of coverage.

18 And then this chapter to me is about what do you get when you're covered, and it really is laying out,
19 I think, a critical fact, without saying necessarily what is right or wrong, but laying out the fact that we have
20 an equal coverage for children across the country, depending on what state they live in, depending on what
21 type of insurance their parents have, et cetera, and then the next chapter, which we haven't gotten to yet, but
22 it really takes that then to we've had the big CHIP discussion. Then we've talked about the cost to the
23 parent. Then we've talked about the benefits, and then we're going to set up for access via the network.

1 So I really like the frame-up. I'm sure that Anne and her staff worked to lay it out like that. So
2 my takeaway on this chapter, because I'm really kind of thinking about what's the whole thing going to look
3 like, and I think that's what we really need to continue to wrestle with.
4 I don't know, in my own opinion, if we have to do much more than just say, "Here, they're different.
5 This is how it's different and why it's different." We can certainly raise policy implications and questions.
6 Clearly, we're not ready for much more than that.
7 But I really do like -- I will just say too I really like the layout.
8 CHAIR ROWLAND: But I also think that we need to be sure to include Sara's point that these
9 are not benefits fixed forever, that in these programs, these benefits often can change.
10 Mark.
11 COMMISSIONER HOYT: I thought there was somebody else in line.
12 CHAIR ROWLAND: I got Peter. I got Chuck.
13 COMMISSIONER HOYT: Okay.
14 COMMISSIONER SZILAGYI: No, you didn't get me, but actually, I was going to say the same
15 thing as Sharon, is that it seems to me that the context to this chapter is what do we think the benefits --
16 what are the minimum benefits that children in this income category should have, and how do we reduce
17 the variability? If we think that there is a level of benefits that's critical for this patient population, then
18 variability is not a good thing, and so that's not necessarily the message of the chapter, but to me, it's part of
19 the context of the chapter.
20 So I think I'm kind of saying kind of a combination of what Donna and Sharon were saying.
21 CHAIR ROWLAND: Chuck. I was trying to let Mark jump in, but I won't.
22 COMMISSIONER MILLIGAN: I'm happy to let Mark jump in.
23 COMMISSIONER HOYT: I was just going to say not to miss the obvious. At least with ESI

1 and some of these others, I think we should draw out the point that we already discussed in a different
2 chapter, the financial hurdles kind of to continue the insurance. In many instances, then these individuals
3 or families will be asked to pay more to get less, and I'm not sure that point is made strongly enough.
4 CHAIR ROWLAND: Chuck.
5 COMMISSIONER MILLIGAN: Thanks.
6 So I'm going to sort of touch on a bunch of comments that were just made.
7 I think in this income range, there's a disproportionate degree of chronic illness of different types.
8 I think that's well supported in the literature and otherwise. I think those chronic illnesses often relate to
9 the benefits that we're talking about: mental health, oral health, things like that, behavioral health. So I
10 think that that context could support a notion that there is a benefit protection, that there's a threshold issue
11 there.
12 I think then it also relates back to the chapter we just discussed, which is these are the kind of
13 services that are highly utilized, because the autism services, Ben, that you mentioned are services that
14 people need with some frequency.
15 So I do think that contextualizing it in terms of the health status of the children in this cohort, the
16 particular services they utilize in the CHIP program will help inform the relationship of the benefit
17 discussion also with the cost-sharing discussion, which is highly utilization related.
18 CHAIR ROWLAND: Okay. Andy.
19 COMMISSIONER COHEN: Great, great discussion so far. I just wanted to throw in one other
20 perspective.
21 Once again, with children, they present sort of a special case in the context of what I'll call "public
22 coverage," so Medicaid, CHIP, even the exchange where public -- government-sponsored,
23 government-subsidized insurance really is the dominant form of insurance for children, much more so than

1 for adults, so it's getting close, but it's more so for adults.

2 So, once again, I feel like there is sort of a special case for Medicaid or the public program. I'm

3 saying Medicaid, but what I really mean is sort of the cluster of public programs really has sort of a special

4 obligation to kind of lead on what coverage should look like for children and not Medicaid, you know,

5 where a public program sometimes really follow what's happening in the commercial space. But there are

6 more children in public programs.

7 I also think -- and this is really going a little bit beyond where we are, but we have learned a lot of

8 things in the last 10 or 20 years, and I am the last person with expertise around this table to sort of be the

9 person raising this, but about children in their development and the relationship to health care.

10 Epidemiology in children is changing really dramatically, in terms of obesity and other things, and it

11 strikes me that this is a place where federal government leadership in really thinking periodically about what

12 the right cluster of benefits should be makes a ton of sense. And for it to be a public sort of process and

13 consideration, because the public is actually supporting so much of insurance for kids, I think it is an

14 important place for government programs to kind of lead.

15 So I would just say that's a very overarching sort of context, but I think for me, it's an extra push in

16 the direction of looking for a federal definition specific to children about what essential health benefits

17 should be is a good idea.

18 CHAIR ROWLAND: Okay. Norma.

19 COMMISSIONER ROGERS: I'm wondering, because as I read all the benefits that some states

20 have and other states don't have, one of the things I don't see or that we don't address or maybe it's not

21 addressed at all in either the CHIP or Medicaid programs are preventive services. Are there preventive

22 services, other than immunizations? Isn't that vital in terms of -- if you have someone that has a chronic

23 illness, for instance, asthma, what is it that we're doing to help the family deal with prevention to not get to

1 acute, or is that considered a benefit or not?

2 MR. FINDER: Preventive benefits are one of the 10 essential health benefits as well as well-child

3 or well-baby coverage. In terms of whether or not --

4 CHAIR ROWLAND: Cost sharing.

5 MR. FINDER: Yeah. Without cost sharing in the exchange plans.

6 In terms of whether or not chronic care, preventive services would cover prevention of chronic

7 illnesses or chronic diseases, I'm not sure. I think that's a benefit category issue, or it depends on how the

8 insurer defines that particular benefit or how the state defines that benefit.

9 COMMISSIONER CARTE: Ben, I thought that Table 1, the categories of benefits summarized

10 there was really a pretty good one for a pediatric plan, but as you mentioned, I think audiology exams and

11 services would be an important one. CHIP's plans have included that, by and large.

12 And in case it wasn't clear to you when I sent you that brief e-mail, under autism general services,

13 what I was trying to suggest there, that those general services, there's a whole variety, from social skills

14 building to treatment planning, day treatment, et cetera, that would also lend themselves to other children

15 with disabilities or delays. So if there would be a way to categorize that in a more -- and I think I suggested

16 habilitation services, but sometimes that has a different specific meaning. Then we could feel more

17 confident that we had a category that really would help meet the needs of children who may not be severely

18 disabled, which most CHIP plans don't cover those children. But the children who have some degree of

19 disability or delay could take advantage of that benefit, and it would line it up more as they move from a

20 CHIP to an exchange plan.

21 CHAIR ROWLAND: So just come up with the perfect benefit plan for children, and we're done.

22 EXECUTIVE DIRECTOR SCHWARTZ: I just want to respond to that, just on the limitation

23 that we have of data that were collected by other people, that there's a limit to how much we can lump the

1 services that were collected under different types of protocols.

2 So I understand what you're saying, and if we had collected the data ourselves and could figure out

3 how to re-bucket them, we might be able to do it. But given that they collected both habilitative services

4 and autism services --

5 COMMISSIONER CARTE: I know, Anne, but you know the source for this was like a NASHP

6 survey. NASHP has this great new leader. I'm sure that they could really just re-survey and reformulate

7 those areas.

8 EXECUTIVE DIRECTOR SCHWARTZ: We can also add some notes, Sharon, to get to your

9 point.

10 CHAIR ROWLAND: Okay. Peter, last word.

11 COMMISSIONER SZILAGYI: Just a quick point. This isn't about all the services that should

12 go into a minimum package, although experts and organizations are very clear about what those should be.

13 I want to make a point about the cost sharing. The evidence for children is that other than

14 hospitalizations, children are highly, highly sensitive to cost sharing for virtually every service and virtually

15 all the services that are in the minimal package, as well as services that aren't, EPSDT or other packages.

16 So other than hospitalization, the elasticity is really high. Children are highly -- or it's actually

17 parents because it's their behavior.

18 The data is a little less clear for adolescents. It's just that there's less data, but for other than the

19 adolescent age group, children are highly cost-sharing sensitive. So I think that could play into our

20 deliberations about what should be in the minimal package. If it's not in the minimal package, utilization

21 will go down substantially.

22 CHAIR ROWLAND: So, now we are going to move from the benefits themselves to the way in

23 which they're delivered and the network sufficiency to actually provide the benefits. And, this is the fourth

1 in our package, so we've now gone from one through four of the different issues in CHIP's future that we
2 are trying to tackle in this March report.

3 ### Session 4: DRAFT MARCH REPORT CHAPTER: NETWORK ADEQUACY AND THE
4 FUTURE OF CHIP

5 * MS. DAHER: Thank you. I am going to be presenting our draft chapter on network adequacy
6 and the future of CHIP.

7 Okay. So, as you know, we've been talking about the adequacy of exchange plan networks for
8 children throughout Commission discussions on the future of CHIP. And, as you know, as Chris spoke
9 about earlier, over one-third of children estimated to enroll in separate CHIP in 2016 are projected to enroll
10 in exchange plans if CHIP ends under current law. And, so, many have raised concerns about whether the
11 provider networks used by exchange plans are designed to address the health care needs of these children.

12 However, there's little definitive evidence regarding differences in the networks of exchange plans,
13 Medicaid, and CHIP. So, as you know, more recent MACPAC work, which included further analysis of
14 children's health care needs, examination of the adequacy of federal regulations on network adequacy, and
15 convening a roundtable of experts in pediatric care and network adequacy, has highlighted the lack of
16 research on this topic and on whether CHIP networks are actually better suited for children than exchange
17 plan networks.

18 However, our work to date raises several key policy issues, including the effects of market
19 conditions on issuers' ability to create networks, how to ensure appropriate access to specialty care,
20 measures of network adequacy, network transparency, and how plans and payers balance access, quality, and
21 cost in network design.

22 So, this draft chapter begins with a summary of the health care needs of children, relates these needs
23 to network design, and provides information on the supply and distribution of providers for children.

1 Then, we examine specific issues in designing and regulating provider networks in Medicaid, CHIP, and
2 exchange plans.
3 So, network design needs to balance two key factors: Which providers are needed to ensure access
4 to the insured population, and which providers are available and willing to serve those enrollees.
5 And, as the draft chapter discusses, children's unique health care needs really have important
6 implications for network adequacy. These needs have been summarized as the four Ds, and they are:
7 Developmental change, differential epidemiology, demography, and dependency.
8 Additionally, the supply and distribution of providers for children will have significant implications
9 for the design of provider networks. There's substantial geographic variation in the supply of primary care
10 providers for children, and use of specialists has grown in the past decade to nearly equal that of
11 non-pediatric specialists. Most specialty care is concentrated in urban tertiary care centers and inpatient
12 care for children with chronic conditions is increasingly concentrated in children's hospitals.
13 So, as we discussed in the June 2014 report to Congress, network adequacy regulations are largely
14 similar between Medicaid, CHIP, and exchange plans. Some new guidance and information has been
15 issued, namely the CMS draft 2016 Letter to Issuers in the federally Facilitated Marketplaces stating that the
16 reasonable access standard will still be used for 2016 and that networks will be monitored throughout the
17 year; the HHS proposed Notice of Benefit and Payment Parameters for 2016, which encourages plans to
18 offer new enrollees the option to stay with their current providers for a transitional period and requires
19 exchange issuers to publish provider directories that are up-to-date and easily accessible; as well as an OIG
20 report on access to care in Medicaid managed care, calling for improved state and federal oversight of
21 managed care plans.
22 So, our work to date has really highlighted several key issues that affect network adequacy and the
23 successful creation of networks that meet children's needs, including contracting challenges. It may be

1 difficult to contract with providers that are members of a relatively rare subspecialty or are the only type of
2 provider -- the only facility of their type in a region. Some providers may not want their names to appear
3 in network directories because they don't want to attract large numbers of Medicaid patients. Or, some
4 providers are willing to accept some Medicaid patients, but only on a case-by-case basis, so not as part of a
5 network.
6 Specialty care: It can be challenging to connect children to needed specialty care due to gaps in the
7 supply of certain specialists at the population level as well as gaps in certain geographic areas.
8 Dental care: The network adequacy challenges in dental care really mirror those in medical care,
9 and they include provider participation, network transparency, and affordability.
10 Balancing access, quality, and cost: Wide networks and correspondingly high premiums do not
11 necessarily ensure access or quality. From a plan perspective, regulatory requirements for wide networks
12 could limit plans' ability to negotiate lower costs or require quality improvements. From a consumer
13 perspective, there is a concern that exchange plans could discourage enrollment of some children with
14 special needs by not contracting with certain pediatric providers who care for these high-risk, high-cost
15 patients, though the ACA does prohibit discriminatory benefit design.
16 Network transparency: While provider directories are currently the only real source of provider
17 participation information for consumers, making them accurate and meaningful for consumers is still a
18 challenge.
19 And, finally, measuring and monitoring network adequacy: Networks can change throughout the
20 year, so up front as well as ongoing monitoring is important. And, in addition, plans may not be able to
21 create a network that meets the needs of 100 percent of their enrollees, especially those who have special
22 needs, and so they may need to create policies to accommodate those unique cases.
23 So, thank you. I'm happy to take any comments on the draft chapter or any questions.

1 COMMISSIONER ROSENBAUM: Thank you very much -- oh, I'm sorry. Oh, Herman, go
2 right ahead.
3 COMMISSIONER GRAY: Thank you.
4 COMMISSIONER ROSENBAUM: Yes. Sorry.
5 [Laughter.]
6 COMMISSIONER GRAY: I know it's a shock. I'm talking.
7 [Laughter.]
8 COMMISSIONER ROSENBAUM: No, no, no. She looked this way and I couldn't tell, so I
9 thought she was looking at me.
10 COMMISSIONER GRAY: I'm easy. I think this chapter is a good first draft for this. And,
11 sort of echoing Andy's comments about benefits, the role that public programs have in providing care to
12 children, you know, is just as important, I think, in this discussion about network adequacy, and certainly
13 kids with special needs, who, as the chapter points out, represent a small percentage of kids but a significant
14 percentage -- I think it's 70 percent that's quoted in the chapter -- of health care costs. And, so, while there
15 are clearly complex, significant challenges in developing adequate networks, including market dynamics and
16 contracting challenges, I think it is essential that because the percentage of kids who require fairly
17 sophisticated levels of care, it's really important that the network reflects that capability, and I think we
18 could strengthen that description, or that discussion in the chapter, a bit.
19 I agree that supply and demand is what sort of drives the development of networks, but I would
20 suggest that, first and foremost, what drives the composition of the network is patient or recipient needs
21 and some discussion -- although there is certainly scant data or evidence to support it -- what are the risks of
22 our grand social experiment with narrow networks. You won't know for years later if it was a good idea or
23 not. So, I think that this is really an important chapter to get right.

1 A couple other comments. I would actually -- you know, you have an -- and I will give you my
2 written comments, but I would actually change the title, Network Composition Depends on Supply and
3 Demand. I think that makes it more of a business model than a care model. I'd work with -- I don't have
4 a suggestion, of course, for what that ought to be, but I don't like it.
5 [Laughter.]
6 MS. DAHER: I think you're right, and maybe what I can do is make it more clear, because I
7 intended demand to encompass also the needs of the insured population. So, it probably wasn't clear.
8 COMMISSIONER GRAY: Yeah. I think we just need to beef it up like that, maybe.
9 I learned something that I had never heard of before, "the four Ds", which is sort of distressing to a
10 pediatrician --
11 [Laughter.]
12 COMMISSIONER GRAY: Yeah. Nor have you. Good. So, I found that interesting. It
13 doesn't quite capture it, but I don't think it's critical to the chapter.
14 I suppose -- I don't know if this is a comment on what's in the chapter or really just an editorial
15 comment, but we don't discuss in much detail whether or not adult networks should be able to respond to
16 any need that adults have for care, no matter how rare, unusual, esoteric they might be, but it's become a
17 significant issue in the design of pediatric networks, and I think that doesn't make sense to me. It's an
18 inequity that I don't think is really acceptable, even if there are states that don't have children's hospitals and
19 that care is concentrated in urban environments. You know, that's just sort of the way the market is right
20 now because of the challenges in training pediatric subspecialty providers.
21 The area -- you identify the area of measuring and monitoring network adequacy, and I think that --
22 I was surprised -- I guess "surprised" may not be the right word, but sort of dismayed that there's so little
23 oversight of network adequacy. You know, self-attestation and that sort of thing is really kind of weak.

1 If there is, indeed, controversy in an area like this as to whether or not a pediatric network is sufficient, there
2 either needs to be better monitoring and oversight and/or appeals process for families who may want their
3 child to be seen in a certain place but the network doesn't allow it. And for -- again, because of the
4 epidemiology of disease in children, I think that is really particularly important.
5 And, lastly, I guess, I would touch on the notion of transition, which you raise, I think, very nicely,
6 and even I understood it. You know, the notion of if, indeed, CHIP goes away, how does that transition
7 occur and should there be a requirement that the previous network that a family was using -- there should
8 be some expectation that a family isn't just unceremoniously transferred from one provider to another.
9 You know, if a child has complex congenital heart disease that's been cared for for the last 12 years by one
10 group of cardiologists and they just get transferred someplace else, as an example, it's just not really great
11 care.
12 So, overall, I would say it's really a great first draft and I'll give you the rest of my written comments,
13 for what they're worth.
14 COMMISSIONER CRUZ: I think in terms of the, in particular, the dental care, analysis of the
15 adequacy of the network is quite limited. There are a -- although controversial among certain sectors of
16 the oral health community, but there are many demonstration projects going on around the nation,
17 specifically, for example, in Minnesota and other states, where they are trying to include non-dentists and to
18 have non-dentists actually deliver preventive services for children, such as nurse practitioners, and North
19 Carolina has physicians and pediatricians. It made a lot of the issues that related to reimbursement by
20 Medicaid, so I think it's very appropriate here.
21 There are other states that are in different stages of allowing dental hygienists and other what are
22 called dental therapists sort of to be trained specifically to deliver services to this population, to underserved
23 populations, to Medicaid and CHIP populations. As a matter of fact, there is a section in the Affordable

1 Care Act that calls for demonstration programs for alternative -- for what they call alternative oral health
2 care providers that is authorized but was never appropriated. So, I think all this should be mentioned here,
3 because not only dentists can provide these services, but there may be others that can be -- specifically
4 preventive services -- that can expand that network.
5 COMMISSIONER ROSENBAUM: There. See, I'm asleep. Actually, I had a question for
6 Herman, and --
7 CHAIR ROWLAND: Starting off the conversation.
8 COMMISSIONER ROSENBAUM: Exactly. So, my question is -- and it may be that Peter has a
9 sense of this, too, but I think of Herman for this issue -- in the case of adult medicine specialists, I think of
10 the availability as somewhat diffuse. That is, there are specialists who practice at hospitals. There are
11 specialists who practice in medical groups independent of hospitals. I realize it varies throughout the
12 country. But, my sense is that it's diffuse.
13 My sense of pediatrics is that, at least in markets where there's a children's hospital, the only place
14 you're going to find specialists is at a children's hospital. They're anchored there because their revenue
15 base is so much more fragile. I mean, it's all public insurance.
16 And, so, I'm just wondering whether in our chapter we have to note that what is a -- that the
17 fungibility issues are going to be different for children. That is to say, with adult medicine, you could
18 imagine that there might be several different oncology groups. There might be several different cardiology
19 groups. But, with pediatrics, not only will there be fewer groups, but they will be highly concentrated.
20 They'll be anchored at certain institutions in the community.
21 And, so, I guess my question for Herman was, is that an accurate perception of a difference between
22 adult specialists and pediatric specialists, so you'd have more choice, really, and more diffusion with adults
23 and less with children.

1 COMMISSIONER GRAY: Yeah, I think it's a very accurate description, with the exception of
2 neonatologists, who are in nurseries pretty much in community hospitals all over America because of the
3 concerns about responding quickly to a bad delivery.
4 COMMISSIONER ROSENBAUM: Right.
5 COMMISSIONER GRAY: There are almost no pediatric subspecialists who are able to practice
6 in private settings, office or otherwise, either because of the payer mix and they have to be subsidized by an
7 institution, or because you need a large population to support a pediatric subspecialist because the
8 conditions are, by definition, uncommon. And, so, it's a -- and, the sheer numbers of these subspecialists
9 are just so small, as the chapter does point out that many specialties, there are a thousand or so of those
10 "ologists" in the entire country. It's just really very small numbers.
11 COMMISSIONER ROSENBAUM: So, the ramifications of keeping a children's hospital out,
12 whether it's a freestanding hospital or a division of a bigger hospital, are much -- potentially much larger
13 than they would be for adults' hospitalization.
14 COMMISSIONER GRAY: Yeah, no question. It's not just a high level hospital that's playing
15 hardball on a contract. I mean, you would really be keeping out the docs who are most likely to -- and
16 other caregivers who are most likely to be able to care for those children.
17 COMMISSIONER SZILAGYI: Could I just expand on that? You're absolutely right, and let me
18 just use an example to explain it. So, most adults -- there are going to be 30 million adults with diabetes in
19 ten years. Most adults with diabetes are cared for not by subspecialists, but by generalists. That's not the
20 case for child diabetes. Most children with diabetes are and should be cared for by pediatric subspecialists
21 because it's clear that the quality of care is better when they're cared for by pediatric subspecialists. And,
22 the only pediatric subspecialists who care for diabetes are in children's hospitals or in other pediatric type of
23 hospitals.

1 So, that's just using one example to explain your point. Other than pediatric allergists, the vast
2 majority of pediatric subspecialists are located in hospital settings for the reason that Herman describes.
3 COMMISSIONER RETCHIN: I think you're absolutely right. The difference is really in the
4 disease, because in the pediatric population, almost -- well, although it's changing because of childhood
5 obesity, but the majority are Type I diabetes, and in adults, that's switched to much more of a Type II,
6 which has really a primary care element to that.
7 So, it is amazing to me, just parenthetically, that here we are in 2015 -- do you realize there are only
8 -- with diabetes being one of the most profound chronic diseases of our time, there are only two types?
9 [Laughter.]
10 COMMISSIONER RETCHIN: What is that?
11 COMMISSIONER CHECKETT: To simplify it.
12 COMMISSIONER RETCHIN: Well, in the personalized medicine area --
13 COMMISSIONER CHECKETT: I see another chapter coming.
14 COMMISSIONER RETCHIN: Yeah, really. Yeah. But, in any case, I think you're right, but
15 it's because of the nature of the disease.
16 CHAIR ROWLAND: Patty.
17 COMMISSIONER GABOW: There's one other point that Peter and Herman want to weigh in
18 on, at least I saw over the last decade as a CEO trying to create coverage, and that is I think a decade ago,
19 adult specialists -- subspecialists -- had a -- were more willing to care for children with a disease or disorder
20 within their subspecialty. But, as pediatrics has become increasingly subspecialized, just like medicine did
21 two decades ago, it became a real issue. And, I think that that should be talked about, I think, if we know
22 that's true.
23 But, I know that we -- our cardiologists would no longer see a child with cardiac disease.

1 Neurosurgeons, even in a trauma hospital, were nervous about being the neurosurgeon on call if they
2 weren't used to taking care of -- and the younger the kid was, the bigger the issue.
3 So, I think the growing subspecialization in pediatrics and the growing reluctance of adult
4 subspecialists to care for children makes this problem magnified, and so I think that should be mentioned --
5 if you agree that it's true.
6 COMMISSIONER MILLIGAN: Part of this conversation is just, I think, highlighting for me that
7 a lot of the providers we're talking about are becoming more and more part of an employed model and less
8 and less part of an independent provider or independent group model. And, so, I think it's often the
9 children's hospitals, as we've been talking about, but it's also often academic medical centers where there are
10 training programs, sometimes tied to children's hospitals but sometimes not. But, by and large, a lot of
11 pediatric subspecialties are now becoming part of employed models, which has implications for network
12 adequacy and access, because from a CHIP program or Medicaid program perspective, if you want access to
13 the physician but not necessarily everything that that system wants to offer, it's hard to build out your
14 network selectively. And, so, I think that that dynamic merits some discussion.
15 CHAIR ROWLAND: I guess you're going to need to re-label this chapter. But, as we've talked,
16 it seems that this chapter is more about access to needed services than just about network adequacy. So,
17 thank you.
18 At this point, we, instead of waiting until the very, very end of the day, wanted to give anyone who
19 has joined us in the audience the opportunity if they want to comment. This concludes our discussion at
20 this meeting for today. We'll resume tomorrow about CHIP. But, if there's anyone who would like to
21 offer a comment, to please come to the microphone now.
22 We also do encourage you, if there are thoughts that you had while you were sitting here, or later
23 when others read the transcript, that you would like to share with us, please feel free to submit written

1 comments and to give us any other information you think we need to have to weigh in on our decisions.

2 ### PUBLIC COMMENT

3 * [No response.]

4 CHAIR ROWLAND: One, two, three. We got it right? Okay. So, we will now take a ten

5 minute recess and then reconvene to go to the other end of the age spectrum.

6 * [Recess.]

7 CHAIR ROWLAND: Okay. Time to resume for a mental health break.

8 While we always have been focused on CHIP and on issues with CHIP, today we're going to turn in

9 this session to looking at an outstanding issue in both Medicaid and the CHIP program, which is something

10 that -- the slides aren't ready yet, but -- we're giving Amy a mental breakdown here.

11 [Laughter.]

12 CHAIR ROWLAND: Which is behavioral health, which is clearly a critical part of the Medicaid

13 and the CHIP benefit packages, also a benefit that is not always very well delivered and for which there are

14 great needs. So Amy is going to open by reviewing the draft chapter and the work we have in progress on

15 behavioral health.

16 ### Session 5: DRAFT MARCH REPORT CHAPTER: MEDICAID'S ROLE IN

17 BEHAVIORAL HEALTH

18 * MS. BERNSTEIN: Okay. Thank you, Diane. Yes, changing lanes for a minute, let me remind

19 you that this is sort of our first foray into this area, and you really haven't discussed behavioral health issues,

20 by which we're including both mental health and substance abuse issues, in many of our past meetings, and

21 so this is sort of our first serious effort to just bring the basic issues to you from a very high level. We

22 haven't separated out different groups of behavioral health clients, and we haven't looked at different

23 populations because sort of our first foray into this area was to sort of lay out what the issues were, the

1 importance of behavioral health to the Medicaid program, sort of how complex the whole delivery and
2 payment system infrastructure is, including the interaction of Medicaid and other behavioral health funders,
3 of which there are many; and then to lay out some very broad issues for your policy consideration.
4 Obviously, in future meetings and in future analyses, we will delve down into one of the probably
5 100 different paths that we could possibly take and do additional analyses on additional populations,
6 additional types of services, focus in on the policy issues that you're interested in, but just to remind you,
7 this is our first foray, and this is really at the 10,000-foot level.
8 So the first part of the chapter very, very briefly describes the evolution of the behavioral health
9 infrastructure and program in the Medicaid environment. Originally, behavioral health was pretty much
10 not considered to be in the purview of the Medicaid program as far as psychiatric facilities were concerned.
11 There was actually an exclusion that did not allow anyone except persons age 65 and over to be treated in
12 psychiatric hospitals, and the thinking behind that was that that was the function of the state, that those
13 hospitals were not good places for people to be, and that they would be better served in community
14 environments, which is still the thinking; but because they did not want to encourage people to be in
15 psychiatric institutions, they prohibited federal financial participation and federal payment for services
16 provided in those facilities except to persons 65 and over.
17 Over the years, there have been better drugs and treatments. There have been more and better
18 home and community-based services, and there has been a shift to home and community-based care and, in
19 addition, towards more self-directed care, which takes into consideration the needs and wants of the client.
20 Behavioral health is of extreme importance to the Medicaid program. Almost a third of Medicaid
21 enrollees age 18 to 64 -- and the reason that it's 18 to 64 is because we excluded dual eligibles from our
22 estimates because we can't really measure their Medicare care with Medicaid data. And these data come
23 from the National Survey on Drug Use and Health, which I presented also at the October meeting.

1 Almost a third of Medicaid enrollees in this age group had any type of mental illness, and this was
2 determined by a series of questions in the survey, compared to 17 percent of the privately insured and 21
3 percent of uninsured people, and 10 percent of them had serious mental illness compared to only 3 percent
4 of privately insured persons. And there were also high levels of drug and alcohol use or abuse in the past
5 year compared to the privately insured population. So it's a lot of the Medicaid population that is affected.
6 CHAIR ROWLAND: Were you able to distinguish there between the eligibility pathways, those
7 who came in as adult parent versus those who came in on the disability rolls?
8 MS. BERNSTEIN: These are from the National Survey on Drug Use and Health, so they did not
9 have any information on Medicaid eligibility.
10 CHAIR ROWLAND: But I think it's worth us remembering that many of the people who are
11 coming in as adults, especially in the pre-expansion period, will be coming in in the disability category
12 instead of in the parent category.
13 MS. BERNSTEIN: Yes.
14 COMMISSIONER MILLIGAN: And, I'm sorry, I just wanted to jump in, a couple of just factual
15 things. The IMD exclusion is ages 22 to 64. It's not zero to 64, so I just want to catch that right away.
16 MS. BERNSTEIN: I'm sorry. I was talking about in 1965, in the original legislation, it was only
17 the 65 and over that were excluded. The child was added in--1972?
18 COMMISSIONER MILLIGAN: Yes. For purposes of just really quickly, factually, and the
19 other thing is you made a comment that we went zero to 64 to exclude dual eligibles. About a third of dual
20 eligibles are under age 65, and the majority of them come on because of mental illness as the source of
21 disability that's the pathway to Medicare eligibility through SSDI. So I just want to really quickly
22 contextualize what we're talking about here. A lot of duals are under 65, and they become
23 Medicare-eligible because of disability mental illness-related. So I just was hoping to frame what we hear

1 with that factual piece from what you said, Amy. And I'm sorry for the interruption.

2 MS. BERNSTEIN: Yeah, that is correct. Those data were from the survey, and as you see here,

3 we do note dual eligibles, and we distinguish elderly dual eligibles from other dual eligibles in the paper.

4 This is from Medicaid administrative data, so using all enrollees, including dual eligibles, about one-fifth had

5 a service for which there was a behavioral health diagnosis. Foster children had higher rates than other

6 children who were not foster children, and 41 percent of disabled adults, non-elderly adults, were identified

7 as having a behavioral health condition, and actually 40 percent of the elderly enrollees who were dually

8 eligible had it. And I think we have data on the non-elderly dual eligibles, so it was from different data

9 sources, and it's much harder to distinguish those categories in the survey data, but you are absolutely

10 correct.

11 CHAIR ROWLAND: Bet you they're from all different years, too.

12 MS. BERNSTEIN: Actually, they're both from 2011, so for once, they were actually from the

13 same year. Just serendipitous.

14 All right. Also, these populations, in addition having a high prevalence of behavioral health

15 conditions, also had high expenditures. In particular, foster children have higher expenditures -- foster

16 children receiving behavioral health services, 42 percent of them had -- it was 42 percent of foster children

17 had a behavioral health diagnosis for utilization. And they were 77 percent of all expenditures for foster

18 children, so the foster children with behavioral health diagnoses were a large percentage of expenditures in

19 that group, and their per enrollee total cost -- and this is not cost just for behavioral health services; it's cost

20 for all services -- were almost twice as much, actually more than twice as much. Eleven is more than twice

21 five, right? Okay.

22 So disabled adults who received behavioral health services accounted for 41 percent of disabled

23 adults, but 58 percent of expenditures. So the bottom line here is just that they are a smaller percent of

1 enrollees than they are of expenditures, and they're a high percentage of enrollees.

2 We then briefly, again, at a high level, talk about the covered behavioral health services, and

3 obviously this differs by age group. Children are subject to EPSDT; other age groups are not. But the

4 mandatory services include medically necessary physician inpatient and outpatient services, except for stays

5 in institutions for mental disease for specific age groups, mainly 21 to 64 years.

6 Most services that are considered behavioral health specific services are optional. Prescribed

7 medicines, which all states currently offer, are still optional services, but all states do offer them. And these

8 other services are provided at the discretion of the state, including stays in institutions for mental disease for

9 persons age 65 and over and children under age 21. So many of these services are provided by all states,

10 but they are, again, optional. And then there are other services that are provided under waiver and

11 demonstration authorities; in particular, the 1915(c) and (I) can provide additional services. And as has

12 been alluded to elsewhere, far fewer substance abuse services are covered than mental health services.

13 COMMISSIONER ROSENBAUM: I do think we want to clarify that in the case of adults

14 covered under Medicaid alternative benefit plans that follow the essential health benefit design, all of this is

15 sort of thrown up in the air because we don't know what the scope of the mental and behavioral health

16 services category is. It's going to vary a lot by state. But things that would fall into an optional category

17 for traditional adults are going to b required for the newly eligible, and, ironically, a lot of the newly eligible

18 adults are the adults who will come in probably disproportionately with mental health and substance

19 disorders.

20 So, I mean, this is the dilemma we now face in Medicaid. If you are an adult who is fully disabled,

21 this is, you know, what you face. If you are an adult who is poor and you may well be fully disabled, but,

22 you know, it's a different benefit design.

23 MS. BERNSTEIN: Although mental health parity does apply, and the IMD exclusion also applies.

1 COMMISSIONER ROSENBAUM: But not in fee-for-service Medicaid, it doesn't. Parity does
2 not apply.
3 MS. BERNSTEIN: No, no. For the alternative benefit.
4 COMMISSIONER ROSENBAUM: Yes, exactly. The IMD exclusion would apply, but a lot of
5 the things that we're calling optional are optional for traditional adults.
6 MS. BERNSTEIN: Yes.
7 COMMISSIONER ROSENBAUM: And not necessarily for the newly eligible.
8 MS. BERNSTEIN: Yes, although mental health and substance abuse services have to be covered.
9 It's not clear how.
10 COMMISSIONER ROSENBAUM: Exactly.
11 MS. BERNSTEIN: Yes.
12 COMMISSIONER GABOW: I think it would be useful, because maybe it's just me that doesn't
13 understand it, but the law about mental health parity, what really is that law? And how, really, is it being
14 applied across everything? I mean, it seems the government programs themselves don't sort of align to
15 that law, but maybe it's because, not being a lawyer, I have no understanding of the details of that law. But
16 I think starting out with something about what is in that law and what its implications are would be useful.
17 COMMISSIONER RILEY: That's actually my point as well, because I think you've got an
18 apples-and-oranges that's pretty profound. In fact, we had a legislator who felt like as long as there's
19 mental health parity, those people who had some private coverage who are on Medicaid, there would be
20 savings to Medicaid. It's not the case because the Medicaid benefit, except for the alternative benefit, is
21 singularly different than what a benefit looks like in mental health parity. So I do think we really need to
22 address that and define it.
23 MS. BERNSTEIN: Okay. Moving on, we then, again, very briefly and at a very high level, talk

1 about the considerable state variation in how they pay for and organize behavioral health services, and doing
2 this justice in a foundational chapter is quite difficult. Behavioral health faces all of the same issues that
3 other Medicaid services face with regard to, you know, how states differ and payment methodologies and all
4 of the other things. But then it's often paid differently, so you have separate, different, coordinated/not
5 coordinated. So there are states that pay everything fee-for-service. There are states that pay everything
6 through managed care plans, although not necessarily the same managed care plans for mental health and
7 substance abuse -- and/or substance abuse and other services. But then you also have different payment
8 methods and different delivery systems for different populations. So, for example, the severely mentally ill
9 might be in a different program than the not severely mentally ill. Children might be in a different one
10 than adults. They might be under different waivers. So finding a really clean way to describe this other
11 than states vary, programs vary, populations vary, providers vary is difficult. But we tried.
12 In addition, there have been sort of -- there has been attention to new methods to try to provide this
13 care more effectively and cost-effectively, and several new types of programs have come into play, many of
14 them in recent years. Many of them have been around for a while, but in recent years there's been a lot of
15 attention to trying to rationalize these services. And some of the most common ones -- and these are not
16 by any means all of them; there are many new types -- are the primary care case management programs
17 which are similar to the ones that are found in the fee-for-service system, but you basically have a case
18 manager who tries to coordinate care for persons who have been identified as having behavioral health
19 needs that need to be coordinated.
20 Behavioral health organizations are commonly used. They are organizations that specialize in
21 behavioral health, and it has been touted that some of the advantages of behavioral health organizations is
22 that they know how to deal with this population, that they have networks in place where other delivery
23 systems may not. So some states contract exclusively with behavioral health organizations. You have the

1 new health homes that were set up under the Affordable Care Act, and there are currently, I believe, 16 of
2 them, of which -- I have the number in the chapter. I think it's seven are specifically geared towards
3 people with mental illness or substance abuse or serious emotional disturbance in children -- actually, it's not
4 seven, so strike that. It's a subset of them.
5 And then there are many other initiatives that are attempting to coordinate and integrate behavioral
6 health and other services through a variety of configurations, and actually at one point in the chapter I had
7 several pages on all of the different dimensions of behavioral health integration, and then I took it out
8 because it was very complicated. But it's everything from a case manager who looks at both the medical
9 and behavioral health services to providing care through one organization where there's actually
10 coordination of care.
11 [Inaudible comment off microphone.]
12 MS. BERNSTEIN: Okay. Thank you. I couldn't remember the number. I'm sorry.
13 COMMISSIONER RETCHIN: Yeah, I was just wondering, there's no mention made of this, and
14 I'm not suggesting there should be, but I just wondered if you had any intent at some point to look at the
15 prevalence of public companies in that space for behavioral health organizations. Of the BHOs that
16 deliver behavioral health, what proportion of those services are through for-profit public companies? It's
17 pretty big, I believe.
18 MS. BERNSTEIN: I will see if I can find something.
19 COMMISSIONER RETCHIN: Just a -- because not necessarily there's any implication there, but
20 in other spaces, there have been some concerns expressed. Sometimes they do it better, and maybe that
21 would be even fine. Just a question.
22 MS. BERNSTEIN: I will see what I can find.
23 And, in addition, if that weren't complicated enough, as I believe we talked about in October, the

1 behavioral health system in Medicaid sort of pushes against many other independent systems, both for
2 substance abuse and mental health that provide either payment or services. And these include, but, again,
3 are not limited to, state and local mental health authorities, HRSA, the Health Resources and Services
4 Administration, through its federally qualified health centers and community mental health centers; the
5 Substance Abuse and Mental Health Services Administration, which provides a large amount of funding
6 specifically for substance abuse, but also for mental health; the Department of Education through its
7 vocational rehabilitation system; and the criminal justice system, which interacts in a variety of ways -- or
8 doesn't interact with Medicaid but often shares many of the same clients.
9 These programs may have different eligibility. Enrollees/clients may have to go on and off these
10 programs in order to qualify for benefits. Sometimes they're conflicting and this can make navigation
11 difficult for an already very vulnerable population.
12 So that is the sort of very high level of the beginning of the chapter, and then we again have some
13 very high level policy questions that our thought was that you may want to investigate in much more depth,
14 which would require future analyses. And this is not all possible questions, but these were sort of
15 examples of large areas where you might have some interest in pursuing additional investigations.
16 So one very broad question is: How does the current benefit design affect access? Are people
17 getting what they need? If they're not, what are the barriers to this? And what are the policy solutions if
18 we can identify the barriers?
19 What are the provider issues? Is it sufficient? If it's not, what are states doing to try to increase
20 it? We could investigate what states are doing in that regard? What steps have states already taken?
21 And what policies should be undertaken? Not necessarily what they have done, but what could they do or
22 what should they do to ensure that affected enrollees receive needed care?
23 Again, these are very broad and would have to be refined in future policy analyses. And I'm not

1 mentioning the effect of the ACA here because that is a separate question, just arbitrarily. How does
2 payment affect what is being provided? And what's the best way to control increasing expenditure growth
3 while still ensuring appropriate use of services, including effective medications and for specific groups?
4 So what are the promising initiatives to control behavioral health care costs overall? And how can
5 the quality be improved? And in the paper, we talk about issues with trying to measure the quality of
6 behavioral health services and problems with doing that.
7 You expressed at the October meeting strong interest in looking at how states are integrating or
8 attempting to integrate behavioral health and medical services. What are the advantages and disadvantages
9 of carving the system of these services in and out? States seem to be experimenting. Many states have
10 carved in; they have carved out; they have carved in again. You know, sort of why are they doing that?
11 What are the advantages and disadvantages? What are any outcomes that we can discern and learn from?
12 And how are they trying or attempting to integrate behavioral health and medical services? There
13 have been many studies. The results are not compelling for some populations. They're more compelling
14 for other populations. But, again, depending on how you define integration and for what populations
15 you're defining it for, there have been several meta analyses that show that, for example, screening for
16 depression in primary care is very cost-effective in some cases, depending on how they do it. Sometimes
17 there's evidence that it provides better outcomes, but that the costs of actually doing it don't mean that
18 there's overall program cost savings. Sometimes there are. And how are these different kinds of program
19 affecting cost, access, and outcomes? And as I mentioned I think early this morning, we are going to do a
20 project that is trying to catalog what states are doing with respect to behavioral health integration across
21 states.
22 You also mentioned at the October meeting that you were interested in how the Medicaid system
23 can be better aligned with other systems that provide behavioral health care.

1 The criminal justice system in particular is one area which might be of increased relevance, given the
2 ACA and the new adult group where there are non-elderly people who might interact with the criminal
3 justice system more than in the past, and there have been some studies that trying to have programs that
4 coordinate Medicaid coverage with incarceration can be very effective in reducing both incarceration and
5 emergency visits in hospitalizations, and that there are things that states could do.
6 For example, New York is allowing incarcerated people -- they're suspending their Medicaid
7 enrollment, rather than terminating it, so that they don't have to requalify when they come out. Helping to
8 ease the transition, North Carolina has also done this recently.
9 But also, coordination with other systems, with substance abuse system -- and there are issues, let's
10 say, with the IMD that affect provision of substance abuse care.
11 What are promising models of agency and organizational collaboration? Some states have merged
12 their mental health and Medicaid programs. Why do they do that? How is that going?
13 And another issue that has come up in many of the discussions that we have had and that you, I
14 believe, mentioned last time is how can data be shared. It is very difficult to coordinate care between
15 medical and behavioral health systems when it's very difficult to share the data because of HIPAA or other
16 restrictions.
17 Another thing that has been in the policy arena of late, actually for quite a while, is whether the IMD
18 exclusion should be reexamined. The IMD exclusion, as was mentioned, prohibited federal financial
19 participation for primarily people between the ages of 21 and 64, which means that the federal government
20 portion is not paid for psychiatric hospital and other institutions of mental disease stays. And an
21 institution for mental disease is defined as an inpatient stay at a facility where more than half of the residents
22 have a diagnosis of mental disease, and this includes substance use. It also has to be more than 16 beds.
23 So small facilities are not affected, but anything with 16 beds or over is.

1 So when thinking about whether it should be reexamined, it's important to look at how it sort of
2 affects different provisions of services. So is it keeping people from receiving inpatient services? Is it
3 keeping people from receiving appropriate long-term services and supports, and what is the effect on
4 treatment for substance use?

5 How does it interact with mental health parity legislation? As we mentioned before, under
6 alternative benefit plans, mental health and substance abuse have to be provided; however, the IMD
7 exclusion still applies, and that makes it very difficult. It has been said by some, especially for substance
8 abuse treatment, which often requires residential care in recollection with more than 16 beds.

9 How does it interact with the EPSDT program? There's a whole series of legal sort of battles
10 about whether needed services under EPSDT would include stays in IMDs. How does it affect waiver
11 programs? 1915(c)'s in particular have to show cost neutrality. If there isn't Medicaid payment for people
12 in these facilities, it's hard to show cost neutrality because there's nothing as a baseline, so that has been an
13 issue. That has been somewhat mitigated by the provision of the 1915(i)'s, which do not require cost
14 neutrality, but there are very few of these programs in effect to date.

15 And what is the relationship between the IMD exclusion and disproportionate share payments?
16 Originally, the thinking behind the IMD exclusion was that people should not -- the federal government
17 should not pay to put people in psychiatric facilities. However, disproportionate share funds can be
18 targeted to psychiatric facilities. So does that go against the intent?

19 All of these would have to be examined when discussing whether -- and it's up to you all to decide
20 whether you think this is something that is worthy of examination.

21 And then the last policy issue presented here, although there are certainly others, is does expansion
22 to the new adult group raise special issues related to the delivery of behavioral health services, and are the
23 new enrollees more likely to have behavioral health disorders? What are their needs? Will this strain the

1 resource environment, and what, if anything, are Medicaid expansion states doing to address any provider
2 shortages associated with the expansion? In addition, this interacts with, let's say, the criminal justice
3 system if in fact more people who are incarcerated or at risk of being incarcerated are now eligible for
4 Medicaid in expansion states.

5 Again, this is very high level. We welcome any focusing that you can do. This is our first foray
6 into this area, so we haven't had a lot of direction from you to date, and we are looking forward to it.
7 Thanks.

8 CHAIR ROWLAND: Thanks, Amy. That was clearly a tour de force.

9 May I ask Andy to begin the questions? And then I will turn to Gustavo and then Trish.

10 COMMISSIONER COHEN: Amy, I don't envy you, this role of trying to boil the ocean around
11 Medicaid and behavioral health, because it's really challenging and hard and large and complicated. And
12 more than almost any other area in Medicaid, it's like almost impossible to find the program in the
13 substance, because there's so much variation across states, localities. There's so many sort of different
14 authorities operating, so it's very, very hard.

15 I think that challenge sort of forces us to really think about how to approach such a big issue where
16 there is sort of so little maybe in common across sort of adult delivery of services.

17 I just wanted to make a couple points about the chapter and the presentation and maybe like a very
18 sort of back to basics. Forgive me if I sound somewhat pedantic. It is much easier to say than to do, but
19 sort of a back to basics on sort of like with such a complicated topic, how do we get some more focus.

20 I thought the data that you presented about sort of prevalence and proportion of the Medicaid
21 population and proportion of people with behavioral health who are in Medicaid, all the different kind of
22 cuts and things that you looked at, it's really in depth and perhaps where the analysis should start. But I
23 did think that we really needed to sort of boil it down to some more key takeaways.

1 The context that I think Diane mentioned, that many people are eligible for Medicaid because of
2 disability and many of those people have behavioral health disabilities or mental health disabilities is a really
3 important framing. I think some of what was in the chapter made it seem like, "Wow! All these
4 low-income people on Medicaid have mental health or behavioral health issues," but a lot of them are
5 actually on for that very reason. So it makes the population look a little bit skewed.
6 I did think that there needed to be a little bit more analysis in all of the recitation of the data, so that
7 we could really sort of have key takeaways like Medicaid is a very significant payer for behavioral health;
8 once again, a leading payer, number one. Number two, it's very hard to maybe -- there isn't good data, and
9 I actually think -- and you can correct me if that's wrong. This is an assumption, but I think data sound the
10 behavior health and Medicaid is maybe not quite as sort of clean, comparable, standardized as some other
11 areas in the Medicaid program, not that those are hallmarks of the program itself, but maybe even sort of
12 tougher in the behavior health space, so I think some comments about what the data challenges are. And
13 if we can't pull out sort of takeaways, I think that needs to be acknowledged more up front.
14 And I also thought a little more discussion about like what is the burden of -- you know, there's lots
15 of you have one condition or a clear division between a mental health and a substance use issue, but what
16 are the diagnoses that are really driving this?
17 In my fairly unstudied perception, it seems like there maybe are two different kinds of challenges
18 that Medicaid has to think about in the mental health or behavioral health -- mental health space, I will say.
19 There's people with really serious mental illness and many with very complicating socioeconomic conditions
20 and factors, and stability and treatment and all these other things are very wrapped up together.
21 And then there's also, I believe, but not really addressed in the chapter, a real challenge of
22 under-diagnosis and treatment of mild to moderate mental illness, depression, and anxiety. They can really
23 have big impact on people's lives, but really handle it in a different sort of context and a different treatment

1 system or not handled.

2 So I did think, again, a little bit more analysis to sort of tease out the key issues might be really

3 helpful.

4 I think on the front, about data challenges, we have to sort of start with what's the problem, and I

5 think there's a lot of sense that maybe our outcomes and quality overall around behavioral health isn't as

6 good as we want it to be, but there's actually, I believe, very little data that's concrete around that because

7 there's not a lot of quality measurement in the field. It's sort of a developing space, but not necessarily as

8 developed as it is in some other areas of health care. So I thought that was sort of an important issue to

9 maybe tease out a little bit more, sort of foundational things, how do we identify what the problems are,

10 what are the barriers to even identifying what they are, and figuring out whether a change could make

11 progress or not.

12 And then I thought -- so that, I thought could be maybe almost a chapter or consideration sort of by

13 itself.

14 When this sort of presentation jumped to the policy issues, I really thought the question of how --

15 we really have to identify the problems first before we can jump to the questions, and I thought the

16 questions were a little too oriented towards maybe an administrative policy, like the IMD exclusion, or a

17 trend towards integration or something like that, without sort of taking that step back and saying what's the

18 problem here.

19 There are some problems that you identify. People die much younger. That's a pretty big and

20 terrible problem and one that we could probably spend years focusing on by itself, again, the sort of

21 morbidity of undiagnosed problems. But I really thought the connection between sort of the problem

22 statement and the policy questions just wasn't quite developed enough in there.

23 So I'm sorry. I've gone on for so long, but I think this was just such an incredibly important space.

1 There is a ton of great material here. I just think the way it is sort of analyzed and structured needs some
2 careful thinking because we don't want to go down paths because there's -- for example, with the IMD
3 exclusion, it is a well-teed up sort of lobbying and financing issue that has come up for many, many years,
4 but the issues behind it and how it kind of affects the system today, I think there's big questions about -- in
5 your paper, you reference some evidence that there's a lack of inpatient beds, and I think that's an arguable
6 point. I think people might have different views on that, and certainly, it might be different in one locality
7 or state than in another.
8 So I think we just have to be really rigorous about our assumptions and facts and figure out our
9 policy questions going forward, and again, proposing a couple of them right off the bat, maybe some stuff
10 around undiagnosed and untreated stuff and around the early mortality and maybe excess morbidity on the
11 physical health side of people who have mental and substance abuse disorders.
12 Thanks for your patience.
13 COMMISSIONER CRUZ: Actually, my question is a good follow-up to Andy's excellent
14 description of the chapter.
15 When you say people with a behavioral health diagnosis account for almost half of all Medicaid
16 spending, does that mean because of the behavioral health treatment or because of other diagnosis?
17 We really don't know, for example, if people with behavioral health have a tendency to have more
18 chronic conditions or if people with chronic conditions tend to develop behavior health issues. Let's say
19 something with a cancer diagnosis could eventually get a diagnosis of depression alongside the cancer
20 diagnosis. So there are two issues here that may be sort of mixed up when you coalesce and present the
21 data this way.
22 So when you are -- and this is not my field of expertise, but when you are thinking about policy
23 issues, like Andy is saying, maybe it would be important to just tease out those things, those two issues, what

1 is behavioral health and what's the rest of the expenditures, how one diagnosis either follows or preceded
2 the other, and that may actually inform issues such as integration of services and other stuff.
3 CHAIR ROWLAND: We do know that people with comorbidities, that someone with your
4 favorite case earlier, diabetes who does not have a mental health problem and someone who does have very
5 different health needs and expenditure levels.
6 It is Trish's term. Then I got Norma, and then I got Chuck, and then I got Peter, and then I got --
7 COMMISSIONER RILEY: Well, it is a very tough issue to get your arms around, so it's good that
8 you have thick skin.
9 It strikes me that we can't decide where the policy ball should go without knowing where we've
10 been, and so the context that seems useful to me would be to think a little bit about how we got here, and
11 when you think about the provider and advocacy roles and so much politics have played into this, I think we
12 understate the role of the mental health agency and that historically states spent. Then when Medicaid
13 came in, Medicaid sort of was an overlay to do Medicaid maximization to get those dollars and save the
14 states' resources.
15 We need to talk more, I think, about Olmstead, consent decrees. This has been an extraordinarily
16 contentious program. We haven't had the chance to step back and say, "Wait! Let's think in terms of
17 policy, not in terms of sort of the advocacy in politics, not that they're not all legitimate."
18 Which brings us to the question of what are the needs for this population, and to Andy's point, we
19 don't know a lot about the evidence about what works, but there is evidence about what works. So let's
20 take that and frame it, so frame the history of how we got here, the needs of the population and the
21 evidence about what helps them, and I think that then informs the discussion of IMD, which I think lacks
22 the context.
23 Do we need more psychiatric beds? I think you're 100 percent right. In some states, we do; in

1 some states, we don't. But if we open that floodgate, we also invite a return to where that history began,
2 which is institutions in an environment where we clearly want to do more community care.
3 So instead of leaping just to the IMD, it seems to me we leap then to a discussion of what ought the
4 benefit to be. We might look at some of the state experiences with PNMIs, which were very successful
5 and highly expensive, but to try to address the housing needs of people with mental illness and to talk about
6 the community support needs, peer supports, all the activities that are in the mental health world now and
7 weigh it against the evidence.
8 So we talk -- instead of there ought to be an IMD exclusion or there ought not to be, there ought to
9 be a benefit redesign that might include psychiatric hospital where appropriate, but a long, an array of
10 services from peer supports to housing. That's where the evidence is, and it seems to me if you start with
11 the history, it's a neat way to sort of walk us to where we've been, what the need is, what the evidence is, and
12 that we need to restructure this benefit.
13 COMMISSIONER GABOW: I think that it might be useful to approach this sort of as we have
14 other things.
15 I think the point you just brought up about the history was not something I had on my list, but I
16 think that's important because it has lots of implications about how this program has evolved.
17 But I think describing the patient population first in a lot of detail will help with this. Then think
18 about the payment policy, which I think has influenced access in a lot of ways.
19 Just to give you an example, in Colorado, every for-profit and not-for-profit hospital in the Denver
20 Metropolitan Area closed their psych beds. Why? Because it paid so much less well than everything else,
21 and the other thing, which as we talk about the patient population, that relates to why these beds are closed,
22 these are difficult patients to have in an inpatient setting. When you get a mix of an inpatient population
23 with both psychiatric and aggressive behavior or psychiatric and dementia, forget trying to put them in a

1 placement for outpatient or nursing home or anything like that.

2 So an understanding of the unique challenges of caring for the population and then the payment

3 policies that make it even harder, I think would be one and two.

4 And access, I think when we talked about access for other components, one of the things we've

5 looked at is what percent of physicians accept Medicaid patients.

6 I can tell you this as an informal survey, but I do not think that there is a private psychiatrist in

7 Denver that accepts Medicaid patients. Now, I may have missed somebody, so that may not be true, but

8 it's certainly a very different number than primary care doctors or pediatricians. I think as we talk about

9 access, we have to think about that.

10 The final thing I would say is where do these services interface uniquely compared to maybe some

11 of the other Medicaid populations, and you started to deal with that. But homelessness, housing, criminal

12 justice, for this population, those are unique interfaces that don't necessarily happen for the Medicaid

13 population over all to the same extent.

14 So I think, thinking about it, the history, the patient population, the payment issues, the access, and

15 the interface with other groups -- and that may be too much for one chapter. We may want to decide

16 which of those pieces go in this first foray.

17 CHAIR ROWLAND: I think this chapter has demonstrated that it's too much for one chapter,

18 and that what we really need is to break this down into pieces, maybe do some fact sheets even on it, and

19 then gear this up as a longer range set of discussions.

20 I have Norma. Then I have Chuck, Peter, Sheldon, and then Mark, and then we do need to move

21 on to the next --

22 COMMISSIONER MARTINEZ ROGERS: I think that everything that Patty was saying, Patricia

23 -- was it Patricia or Patty -- Patty was saying, I really agree with her. It's not only that psychiatrists don't

1 take Medicaid patients, but it's also that there's so few psychiatrists, and in some areas, there are no
2 psychiatrists. So, we fall on psychiatric mental health nurse practitioners to do some of the treatment.
3 I think, though, that when you put adults and children together, it doesn't work. I think children --
4 the children's section needs to be separated from the adults because those issues are so different. The use
5 of psychotropic drugs in children is very different from the use of psychotropic drugs with adults, and the
6 overuse of them with children is outrageous.
7 The other is that I think that when you're talking about barriers, you're also talking about cultural
8 issues. I mean, it's such a complex picture, because it's the cultural issues, and the cultural not only in
9 ethnic-race, but I'm also talking gender, that, you know -- I mean, there's literature that states that the
10 majority of -- there are more blacks diagnosed with schizophrenia than there are any other population, and
11 it's just all the biases.
12 It's a very complex picture, and I'm not sure how to work with that, but I do think that when you
13 deal with children, you're also talking about the foster children, which is a different population altogether in
14 terms of their mental health issues, and the mental health issues of children who are behavioral problems in
15 school but continue to live at home.
16 There is no hospital inpatient, really, in San Antonio. I know for a fact that the inpatient treatment
17 is you go into a hospital. You stay there until your Medicaid runs out, and then you're out, regardless of
18 whether or not you're healed, unhealed, have long-term treatment, or what anything said. So, I think, that
19 needs to be looked at.
20 But, I definitely think that children and adults need to be separated.
21 COMMISSIONER MILLIGAN: As I listen, Amy, I am more and more grateful that you hadn't
22 run out the door, because there's a lot of work here that we --
23 [Off microphone conversation.]

1 COMMISSIONER MILLIGAN: Oh, good. So, I'll try to be brief about this. I think a
2 descriptive part that you've endeavored to do and some of the descriptive stuff folks have mentioned would
3 be helpful in terms of the first foray into this.
4 As I think about it, I think about what's the audience for this and what's the role of the work here,
5 and where that leads me is I think it's less helpful about all of the potential waste to administer these
6 programs, because I think at some level, the -- I just finished, in Maryland, leading an effort about
7 behavioral health reform for the state and I moved to a state where it's a completely different model than
8 that, and both work and fail.
9 So, I think about what would Congress want to hear and what would the administration want to
10 hear, or what would the background of a descriptive chapter be that could help drive policy, and I think
11 about things like the IMD exclusion, to me, the biggest challenge with it is that it leads to a rebalancing
12 problem because you don't have an institutional comparison, and 1915(i) is an attempt to kind of work
13 around that. But, for Congress, was that a successful -- is it successful for rebalancing? Is it successful
14 for Olmstead? Olmstead, by the way, the named plaintiffs had mental illness and in a state hospital. So, I
15 just think, is 1915(i) successful for the Congressional intent?
16 Is the Section 2703 health home model successful, because a lot of -- it's 90 percent federally
17 matched, two-year time limited for each state. Is it successful, because a lot of these models are mental
18 health related, behavioral health related. Is it reducing somatic costs about inpatient stays, EDUs? Is it a
19 successful model? Is it something that ought to become more -- should it be on a glide path to becoming
20 more part of the Medicaid program permanently or not, or is it unsuccessful?
21 I think about things like parity and the point Sara made earlier about, you know, parity is provided
22 inside of capitation, not provided inside of fee-for-service, and what are those implications for
23 Congressional parity considerations.

1 I think about things like churn, because a lot of the challenges when you see people coming into
2 Medicaid or leaving Medicaid is that there's a high proportion of not only mental health and behavioral
3 health diagnoses, but usage -- pharmacy, therapy, and so on. As Medicaid folks go into the exchange and
4 essential health benefits, what are those benefit cliffs, because I think that relates to EH -- the essential
5 health benefits, and that relates to Congressional stuff.
6 I think about network issues a little bit, because behavioral health is a very public system, and in my
7 experience, the challenge is the networks that are around -- maybe capitation inside of Medicaid, but also,
8 certainly, capitation inside of qualified health plans -- they don't typically have public providers, and so
9 there's challenges about that and what are the implications for churn and adequacy and access, because I
10 know that the Congress is going to be taking up some potential legislation soon about protections with
11 churn.
12 So, I was trying -- the main reason I wanted to make these comments is I think that it's less -- to me,
13 it's less helpful to try to get at the granular level of managing 55 Medicaid programs around the country and
14 territories, and to me, it's more, rather, about how can a descriptive chapter inform a Congressional agenda,
15 potentially, and a CMS regulatory agenda, potentially. So, I'll just leave it there. But, I think it was a
16 daunting task and I appreciate you undertaking it.
17 CHAIR ROWLAND: She's going to continue it, too.
18 Peter, and --
19 COMMISSIONER SZILAGYI: Yeah. I'll try to be very brief. I add my congratulations and
20 condolences for taking this on.
21 [Laughter.]
22 COMMISSIONER SZILAGYI: I'm going to try to integrate several things that people said with
23 respect to children and behavioral and mental health for children. And, I do agree with what Chuck was

1 saying, that it may be a little bit too complicated to get into all of the different management strategies. But,
2 as I think about what the problems are, for children, I think about two groups of kids. One is foster kids
3 and the other is all other children.

4 So, let me deal with the first one first, so, children in foster care are a special group. They are the
5 wards of the state, so there is something very special about them that's different than the rest of children,
6 not just from the health insurance point of view, but from kind of the state's responsibility point of view.

7 In terms of management for kids with foster care, I can see, really, two overriding issues. One that
8 hits the headlines is the overuse of psychotropics, and the overuse of psychotropics is predominately
9 because these children are out of control. The reason they're out of control is they've been traumatized
10 and they haven't had sufficient trauma-focused therapy.

11 So, the second point that I want to make about foster care is that, to me, the biggest problem is the
12 lack of trauma-focused therapy, and that has led to the overuse of psychotropics. So, I would kind of
13 categorize the management for foster care into those two categories, and they're actually related.

14 So, for the non-foster care population, I kind of see the problems as being a problem of
15 identification and then a problem of management. So, the problem of identification is that there are too
16 few children who are adequately screened and identified, however that's done. And, I'm not sure I would
17 get into all of the intricate details about that, but there are ways -- there's evidence-based ways to screen and
18 identify children now.

19 And, the problem with management focuses on several different areas. One is that there's parallel
20 systems and they're not really integrated. There are new modalities that aren't too granular, but they have
21 to do with co-management between primary care and subspecialty. So, I would kind of think about the
22 management for the non-foster care -- kind of what are the policy levers for the non-foster care population
23 in terms of identification and optimal management, and that might help organize maybe potentially a

1 pediatric chapter.

2 MS. BERNSTEIN: Can I ask a question? Would you include children who qualify on the basis

3 of disability with the "all other children," or would you exclude them?

4 COMMISSIONER SZILAGYI: Yes, unless they're in foster care. I mean, they could be in --

5 MS. BERNSTEIN: So, if --

6 COMMISSIONER SZILAGYI: If they qualify because of disability, I would put them -- I would

7 personally classify the kids in foster care as separate. Now, that's not so easy, because kids in kinship care,

8 which are not wards of the state, kind of look like foster care, if you look at their health needs, but for now

9 --

10 MS. BERNSTEIN: No. My question was, though, would you include disabled with the

11 non-foster care kids --

12 COMMISSIONER SZILAGYI: Yes.

13 MS. BERNSTEIN: -- or separately from the non-foster care kids --

14 COMMISSIONER SZILAGYI: Well, potentially, a third group --

15 MS. BERNSTEIN: That's my question.

16 COMMISSIONER SZILAGYI: Potentially, a third group, either in a non-foster care or

17 potentially a third group, but --

18 [Off microphone conversation.]

19 COMMISSIONER SZILAGYI: Yeah.

20 MS. BERNSTEIN: Children who qualify on the basis of disability.

21 COMMISSIONER SZILAGYI: I think they could be included in --

22 COMMISSIONER MARTINEZ ROGERS: Physical disability or mental disability?

23 MS. BERNSTEIN: Either. It's just the question is, do you want to lump them in with all the

1 other children, the non-foster children.

2 COMMISSIONER SZILAGYI: I would.

3 MS. BERNSTEIN: You would.

4 COMMISSIONER MARTINEZ ROGERS: I would.

5 COMMISSIONER SZILAGYI: Yeah.

6 MS. BERNSTEIN: Okay. It's just --

7 COMMISSIONER SZILAGYI: Yeah.

8 MS. BERNSTEIN: Okay.

9 CHAIR ROWLAND: Sheldon.

10 COMMISSIONER RETCHIN: I thought this was a great start, and certainly is going to have to,

11 though, develop into a lot bigger area of review than just a chapter. Just a couple of points that I thought

12 that you made, but maybe would develop a little further.

13 First is, although you talked about other behavioral health funders, it would help me to have it in the

14 context of looking at it as a marketplace. That's why I brought up the BHOs and the for-profits that have

15 entered into that space, because in behavioral health, maybe unlike any other, but there are issues that really

16 spread across socioeconomic status as well as payers.

17 Witness -- we are in D.C., but we are not far away from where a state Senator lost his son because of

18 issues, at least implied, by access, and certainly I don't believe he was on Medicaid. That would actually

19 shock me, but I don't know the answer to that. It's Senator Deeds, who ran for Governor.

20 So, in the context of the marketplace, I'd be interested in the question of whether there are adequate

21 numbers of beds and providers in other payers as well as Medicaid, because we all know that no matter what

22 sector or whatever service we're examining in Medicaid, that it's in the context of a marketplace, because we

23 have huge cost shifting. And, so, if there's an inadequate commercial payer, which we know there are at

1 least some assertions on that on behavioral health, then they're unable to cost shift, so it may restrict supply
2 on the Medicaid side.
3 Ditto, you mentioned providers, and I would want at least a little bit of attention paid into the
4 declining interest of American medical school graduates in behavioral health, or at least flat interest, and
5 whether that has implications in the future. It might have some upside because of the restrictions in
6 residency slots in other areas.
7 Lastly would be a point about prisons. So, you have 50 Governors, all of whom are looking at
8 major cap ex, capital expenditures, for new jails and prisons in the next 25 years. These are major, major
9 strategic decisions at the state level, that if there was ever going to be a PAYGO effort to look at the value
10 proposition of mental health, it would be in the data that suggests in variations by state that this decreases
11 recidivism, where you're talking about an annual cost of $50,000 a year to house an inmate today. Some of
12 that is in there, but I think developing that in terms of policy would be useful. Thank you.
13 CHAIR ROWLAND: Okay. Last comment from Mark.
14 COMMISSIONER HOYT: I had two short comments, one related to the prescribing. We had
15 already talked a lot about psychotropics. If we had time or ability to collect this, I'd be interested to know
16 which states are doing a better job with a drug database or triggers that -- it fits with the integration, as well.
17 If you had a pediatrician or an internist prescribe psychotropic meds, would that immediately trigger an
18 e-mail or text message to a psychiatrist, psych RN, chief medical officer, case manager, somebody? How
19 do they communicate those things?
20 One other thing on the history. It's too bad Sara had to go, I guess. When we would do rate
21 setting, we would frequently run into, like, a seminal lawsuit in a state that defined medical necessity or
22 reimbursement or something else, a bunch of them. I think there was one around a guy named Salazar in
23 D.C. I know Arnold v. Sarn was around forever in Arizona. And, it's a pretty striking difference between

1 the acute care physical health, to go into behavioral health, where you run into these. They're both
2 important for the history, but then they seem to kind of color the personality of the state after that as to
3 how you can manage care. It's, like, no, we can't touch that service. There was the lawsuit, and so now
4 that's hands off. And then when you march through about ten or 15 states, it's just wildly different, the
5 delivery of these different services and how it's approached, to where you really wonder, what is medical
6 necessity, or how do you treat this?
7 CHAIR ROWLAND: So, Amy --
8 [Laughter.]
9 COMMISSIONER MARTINEZ ROGERS: So, Amy --
10 CHAIR ROWLAND: And, thanks. Okay. I do think that there is a lot of depth and richness
11 in what we have here, and we want to pursue it in different chunks and different ways, but I think that this
12 is -- when we talk about something that is not a one-time thing, this is the beginning of a long exploration of
13 what I think is a critically important topic. So, thank you for starting us, trying to give us so much that we
14 told you that we wanted more, but we wanted it in different chunks. So, we'll be seeing you often.
15 Thank you.
16 COMMISSIONER MARTINEZ ROGERS: Let me quickly ask you this. Did you look at any --
17 under children, did you look at any residential treatment centers?
18 MS. BERNSTEIN: [Off microphone.]
19 COMMISSIONER MARTINEZ ROGERS: For the inpatient part of children with behavioral
20 problems. Many of them go to residential -- what they call residential treatment centers.
21 MS. BERNSTEIN: For this analysis that's in the paper, we didn't look at site of care. We actually
22 are starting a site of care analysis, and we do have some limited information on residential treatment centers.
23 It's a very small number of overall Medicaid patients. It's not very many people, but we do have some

1 information on it.

2 CHAIR ROWLAND: What I'd like you to do, Amy, is to come back to us in February, not with a

3 chapter, not with stuff written, but with kind of a set of bullets of some of the topics that you think we

4 could begin to develop as different components of our examination of behavioral health. Yeah.

5 MS. BERNSTEIN: You want an analysis plan, right?

6 CHAIR ROWLAND: Yeah.

7 MS. BERNSTEIN: Okay.

8 CHAIR ROWLAND: Or, you know, what questions do we want to answer?

9 But now we're going to ask Katie to come up because we have a whole different set of questions to

10 answer there, and we're going to move here to look at the results of a study we commissioned that helps to

11 inform our continued exploration of the effect of different levels of cost sharing on people's access to care.

12 Here we're looking at the dual-eligible population, the fact that states do not have to pay full Medicaid --

13 Medicare cost sharing for their dual-eligible population, and what the impact of that is. And this is at Tab

14 7, Chapter 6.

15 **### Session 6: DRAFT MARCH REPORT CHAPTER: THE EFFECT OF MEDICAID**

16 **COVERAGE OF MEDICARE COST SHARING ON ACCESS TO CARE**

17 * MS. WEIDER: Okay. Well, I'll try to be brief because I know we're over time. But I'll first

18 start by just giving you an overview of what we'll be going over today.

19 I'll first start by highlighting past Commission work on these issues. Then I'll review our draft

20 chapter, again, located in Tab 7. And then I'll finally conclude with our next steps.

21 So our past Commission work. In our March 2013 report, you will recall that we documented

22 states' use of lesser of payment policies for Medicaid payment of Medicare cost sharing. We built off this

23 work at our October meeting and presented the differences between the Medicare Savings Programs, the

1 MSPs, and presented findings from our analysis on the effects of Medicaid payment of Medicare cost
2 sharing on access to care for dually eligible beneficiaries.
3 Then at our December meeting, we presented policy options on, one, Medicare cost-sharing
4 payment; and, two, MSP eligibility and enrollment. Based on your discussion at the December meeting,
5 the Commission expressed the direction it wanted to take with regard to Medicaid payment of Medicare
6 cost sharing. However, we also heard that the Commission needed more information and evidence in
7 order to consider MSP eligibility and enrollment issues. You'll see that the chapter reflects this direction.
8 So now shifting from our past work to what's now in the chapter. The chapter begins by
9 highlighting the history of Medicaid payment of Medicare cost sharing. It focuses on the interaction
10 between Medicare and Medicaid policy and how changes over time expanded Medicaid's role in paying for
11 Medicare cost sharing.
12 Today Medicaid pays for Medicare cost sharing through the four separate MSPs and through full
13 Medicaid benefits. However, each program differs by individuals served, benefits offered, and the
14 financing mechanism. Additionally, policies, specifically the Balanced Budget Act of 1997, allowed states
15 to pay the less than the full Medicare cost-sharing amount if the payment to a provider would exceed the
16 state's Medicaid rate for that same service. And this policy leads us to the discussion of our analysis.
17 As I previously mentioned, in our March 2013 report, we documented which states utilized the
18 lesser of payment policies. However, in this chapter, we examine how this Medicaid payment policy
19 affects access to care for dually eligible beneficiaries. This study, which is highlighted on page 10 of your
20 briefing materials, suggests that, one, Medicaid payments of Medicare cost sharing varied across states; and,
21 two, higher Medicaid payment of Medicare cost sharing is associated with an increased likelihood that dually
22 eligible beneficiaries will have a Medicare outpatient visit, use preventive services, and have an outpatient
23 psychotherapy visit. However, the study also suggests that higher Medicaid payment of Medicare cost

1 sharing is also associated with a decreased likelihood of using safety net providers.

2 However, access to care is also affected by the administration of payments of Medicare cost sharing.

3 The process for paying Medicare cost sharing can be inefficient and can hinder provider payments because,

4 one, claims for dually eligible beneficiaries must pass through Medicare and Medicaid in order to receive

5 provider payment; and, two, the amount a provider receives is also dependent on the beneficiary's

6 enrollment in a fee-for-service or Medicare Advantage plan.

7 It's also important to note that certain providers can receive bad debt payment to recoup some of

8 these costs. However, as an alternative to this type of back-end payment, some have suggested paying

9 providers up front would be more direct and efficient.

10 So during the October and December meetings, we heard you express concerns that paying less than

11 the full Medicare cost-sharing amount and the administrative process for paying Medicare cost sharing

12 negatively affects access to care for dually eligible beneficiaries. We are seeking your feedback on how

13 these concerns are expressed in the draft chapter we present today.

14 We have received feedback from some of the Commissioners already, and we plan to add additional

15 information on how factors other than payment can affect access to care.

16 Additionally, we heard the Commissioners express the need for more information and evidence in

17 regard to MSP eligibility and enrollment. As a result, we segmented this portion out of the chapter that we

18 present today, and I plan to come back with additional information in upcoming meetings on these issues.

19 And from here I can take any questions and take your feedback.

20 CHAIR ROWLAND: Mark.

21 COMMISSIONER HOYT: I was just wondering if --

22 CHAIR ROWLAND: Oh, it was supposed to be Trish. I'm sorry. Trish first. What we're

23 trying to do is, since we've asked different Commission members to be a primary reviewer of the chapters, I

1 have tried through the course of the day to start with them. But I've just screwed up because I missed
2 Trish, so I'm going to let Trish start.
3 COMMISSIONER RILEY: Thank you, Diane.
4 CHAIR ROWLAND: It's because Mark is too tall next to you.
5 COMMISSIONER RILEY: That's it.
6 I think you did a masterful job in a clear way spelling out the complexity of these MSPs, and it was
7 really nicely done but needs to lead us to the conclusion -- I was channeling Patty thinking about simplicity,
8 simplicity, simplicity. This is so profoundly complicated that it makes it really difficult to address, and I
9 think that's a primary reason for our concern.
10 I also appreciate that we have a shared responsibility over dual eligibles with MedPAC, so we have
11 to think of the avenue that addresses Medicaid. And I think to that degree, I have to -- I suspect Donna
12 and Chuck and I would look at this the same way. When you have your Medicaid hat on, I wasn't really
13 convinced, looking at the data, that there was a significant access problem. When you think about all the
14 other issues Medicaid has to deal with and the balancing act and what you're going to pay for, I was
15 unconvinced in the data that it was significant enough a problem to convince me that I would pay for this
16 rather than, say, oral health or any of the other things we want to do in the Medicaid program.
17 So I think the context of the total spend of dual eligibles would be helpful and sort of look at where
18 Medicaid spends and where Medicare spends. I don't quite understand the RTI methodology and why
19 these particular services were chosen given that the big spend is nursing facilities, hospitals. So I don't
20 know if we can -- this paper, if we conclude that there's an access problem, might lead people to suggest that
21 there's an access problem for all these crossovers. And I think I'd be really worried about that, and we
22 probably ought to address the methodology a little bit more and why this subset.
23 EXECUTIVE DIRECTOR SCHWARTZ: Trish, before you move that, Katie, do you want to

1 speak to why those services were -- so we don't lose the thought? Or do you --

2 MS. WEIDER: Yeah, I can just speak to the context of how much spending on those specific

3 services. So in our October report, we kind of detailed that out in the appendix, and you'll see that

4 Medicare outpatient services account for 30 percent of dual spending.

5 COMMISSIONER RILEY: Yeah.

6 EXECUTIVE DIRECTOR SCHWARTZ: And the reason for these specific services, Trish, it's

7 true that, you know, at the sort of dollar level, they're small services. But they were picked as entry points

8 into care, primary care preventive services, not long-term stays in a nursing home. That's the rationale, and

9 if that's not --

10 COMMISSIONER RILEY: Yeah, I think it wasn't clear to me, but it may be to everybody else.

11 But I think that would help.

12 In the end, though, I think I got down to sort of the equity issue. Why should a Medicaid program

13 pay some providers more for one set of beneficiaries, especially beneficiaries who have a very rich benefit

14 through their Medicare benefit, than we pay other subsets of beneficiaries? And it just seems it's really an

15 issue of equity that the paper needs to address. If the federal government, for example, were to require

16 states to cover this one set of population at a Medicare rate, that's an unfunded federal mandate, unless they

17 fund it fully.

18 So it seems to me between the administrative complexity, the equity, questions about how serious

19 this access problem really is compared to other constraints in the Medicaid program, it leads us to -- I would

20 hope it does lead us to a recommendation, and maybe I come here because I really do have PTSD over

21 crossover claims. I remember spending long, painful hours, so maybe I'm biased. But I really think this

22 is an area where enough is enough and we've got to take a really hard look. We have jerry-rigged a system

23 that is so complicated. Maybe you shouldn't make it so clear because you've done such a great job, it isn't

1 that clear for most people, and certainly not for most legislators. So it's so jerry-rigged, it's so complicated,
2 it's so administratively complex, and the issue of equity about whether it's appropriate for a state to spend
3 more for one set of beneficiaries than for another, it seems to me begs the question of a recommendation
4 about this isn't Medicaid's responsibility or something like that, and we ought to think through what the
5 options would be.
6 COMMISSIONER HOYT: I can't remember if you told us this before or not. Has MedPAC
7 already studied this and made recommendations about what they propose should be done?
8 EXECUTIVE DIRECTOR SCHWARTZ: This is not particularly an area of concern for them, is
9 how I would phrase it.
10 CHAIR ROWLAND: But they have made no recommendation.
11 EXECUTIVE DIRECTOR SCHWARTZ: They have made no recommendations. The only
12 recommendations that they've made on the MSPs was to increase the eligibility level for the QI program to
13 150 percent of federal poverty level. And even though that does have some implications for states, it is
14 fully federally financed.
15 COMMISSIONER HOYT: Well, I would agree or second Trish's comments about simplification,
16 and I do feel like there's a recommendation in there somewhere.
17 COMMISSIONER MILLIGAN: So I have a couple of comments. One is I think that the
18 chapter needs to discuss Medicare Advantage a little bit more. The chapter is really focused on duals who
19 aren't fee-for-service, and there's been a lot of growth in the percentage of duals who are in MA plans and
20 D-SNPs and other acronyms like that. And I don't think that that context is adequately framed, and the
21 extent to which there's duties or not at all with respect to paying providers who are getting negotiated rates
22 from MA plans that are not transparent to Medicaid agencies and are not necessarily 100 percent Medicare
23 fee-for-service.

1 So I think the context that this is a fee-for-service-focused discussion and whatever duties or not
2 apply to MA and what the percentage of duals, full benefit duals for an MA, I think that context needs to be
3 added.
4 I want to go back to Trish's point for a second and just give an example. If Medicaid were to pay
5 $40 for an office visit and Medicare were to pay $50 for the same office visit, I think what we're talking
6 about is should there be a requirement for somebody to pay that extra $10, because that would be the
7 coinsurance mark for Medicare, and if Medicaid should pay it as a crossover, I think that's the context.
8 And paying 50 will get you that visit more often than getting -- than paying 40.
9 So I think that's a real example of the kind of stuff that happens in real life with state Medicaid
10 programs which pay typically below Medicare fee-for-service. To me, the equity issue that Trish raised, I
11 would frame the equity issue a little bit differently. If Medicaid agencies were required to pay the
12 coinsurance up to Medicare levels and not this lesser of, what that would mean is for dual eligibles, and dual
13 eligibles alone, they would be getting access to providers who are willing to serve them for 50 bucks but not
14 40 bucks. And for everybody else on Medicaid, you're asking providers to serve them for 40 bucks for that
15 office visit. And so the equity issue that I get concerned about in this conversation is whether we're
16 disadvantaging non-duals' access to medical care by having a higher rate tied to Medicare fee schedules for
17 duals and duals only.
18 And I'll end this way: This relates very much to the next agenda item with Ben, because if there
19 was some movement to resume or restore payment at 100 percent of Medicare, the two-year primary care
20 bump, it would raise the boat not just for duals but for all Medicaid beneficiaries with respect to that set of
21 services.
22 So I guess they're interrelated conversations a little bit, but I guess the main point I want to make is
23 the equity issue that I'm concerned about is disadvantaging non-duals.

1 CHAIR ROWLAND: Okay.

2 COMMISSIONER GABOW: I would like to understand a little better the sliding scale used for
3 Part D and for raising the premiums for higher earners in Medicare, because I don't -- as I've said before, I
4 don't understand if we slide the scale up in Medicare, the more you make, the more you pay for your
5 premium, why can't we slide the scale down, that if you're poor, instead of asking another government
6 agency to pay your premium and your coinsurance, create a sliding scale that goes from the bottom to the
7 top? So understanding how this works in Part D and for the Medicare premium overall going up I think
8 might inform an alternative for going the other way.

9 CHAIR ROWLAND: I think to your comment, though, Patty, it's very important to keep the cost
10 sharing, which is what we're talking about in this context, separate from the premium. So it's the premium
11 under Medicare that goes up for people for Part B and D who are over -- it's a way of getting revenue to pay
12 for other services. So what we're getting into here is that there's no free lunch in this game, and so if we're
13 saying that Medicare should take over this responsibility, we're moving a big cost onto Medicare at the
14 bottom end, so they would have to make that sliding scale even higher than it is. And there's a lot of
15 concern in Medicare itself that those premiums over time with the income growth in them is going to really
16 reach down to half of all Medicare beneficiaries.

17 So, you know, I think that's where we do get into needing to not go our way alone, but to work with
18 MedPAC, which has an obligation to look at all these things, and they actually have the income data and the
19 information to know who's affected and how.

20 COMMISSIONER GABOW: Well, it's interesting to look at what the numbers would really be
21 since Medicaid is -- there's a federal share in the Medicaid piece that the state is not picking up in the states
22 with a high FMAP. That's a big piece. If you actually look at what the incremental cost would be to the
23 federal government over --

1 CHAIR ROWLAND: You mean if we propose the states get a clawback?

2 COMMISSIONER GABOW: I'm just saying that right now the --

3 CHAIR ROWLAND: I mean, I think you're right --

4 COMMISSIONER GABOW: -- federal government is paying 50 to 75 percent of the Medicaid

5 cost.

6 CHAIR ROWLAND: It's not paying 100 yet.

7 COMMISSIONER GABOW: Pardon me?

8 CHAIR ROWLAND: But not 100.

9 COMMISSIONER GABOW: No, but -- so the delta, given the number of people whom this

10 affects, in the federal government budgetary discussions may not be as big as we think. That's all I'm

11 saying.

12 CHAIR ROWLAND: Well, you know, I do think that over the next months there's like to be

13 continued discussion on the Medicare side about restructuring Parts A and B, the role of Part C, the

14 Medicare Advantage, how all of that fits together with D. So, clearly, there's going to be an opening to

15 begin to look at some of this restructuring. But I don't think it can happen in this chapter. And I guess

16 the bigger question is: What do we want to do right now with this chapter in terms of going forward with

17 putting out the study and how we want to characterize the implications?

18 And maybe you're right, Chuck. Maybe it should be stated that there's some evidence here that

19 cost sharing can be a burden for the duals, but it should be perhaps looked at in a broader context and not

20 just as a solution right now for the Medicaid population.

21 All right.

22 CHAIR ROWLAND: So we will go back to another payment issue here.

23 This is another one of our favorite topics. It's to look at the primary care payment bump, which

1 when we talked about it previously was in effect, and it has now expired. But some places have decided to
2 maintain it; others have not. Ben is going to give us kind of a dimension of where we are and what to say
3 about it.
4 I can only tell you that among the questions that Members of Congress have asked me is, "Oh, and
5 what has MACPAC come up with? What do you know about the primary care payment bump? What
6 did it do? Was it successful in some places?" And the state of Connecticut is making a big case for the
7 fact that it was very effective in their landscape, which, of course, is also because they run their own
8 managed care system.
9 Ben.
10 ### **Session 7: DRAFT MARCH REPORT CHAPTER: AN UPDATE ON THE MEDICAID**
11 **PRIMARY CARE PAYMENT INCREASE**
12 * MR. FINDER: Thank you.
13 So it has been an important topic, and today might be the last time that I am talking about it. The
14 chapter is a bit of a post-mortem on the primary care payment increase, actually. Although it was in the
15 news a lot leading up to December 31st when it expired, and it continues to be discussed, the provision did
16 end, and there is no longer any enhanced federal funding or enhanced federal matching funds to pay for the
17 increase.
18 Today, I am going to walk you through the chapter, which is divided into four sections. The gist of
19 the chapter is that emerging research provides a mixed picture as to the effect of the payment increase on
20 access to care in Medicaid. The research includes feedback that we heard from state Medicaid agencies,
21 Medicaid MCOs, and provider organizations. The draft chapter builds on our earlier work that examines
22 state planning efforts and early issues that states encountered in the implementation of a payment increase.
23 So we'll go ahead and dive in. The chapter includes a brief overview of the statutory and regulatory

1 requirements of the provision. You will recall that not all providers and services were eligible for increased
2 payments under the provision.
3 Providers were required to self-attest to their eligibility based on board certification in three primary
4 care specialties and a number of subspecialties. This proved to be challenging for states and required states
5 to establish a process for the physicians to self-attest to their eligibility.
6 You will also recall that only certain services were eligible for increased payments, which included
7 evaluation and management services and vaccine administration codes related to children's vaccines.
8 The implication of these requirements is that this was different than a typical rate increase or rate
9 change for states. This was a little bit more challenging for them to implement.
10 The provision also proved to be more complicated to implement within managed care programs
11 than in fee-for-service, and the chapter goes into more detail than I will here, but states and MCOs
12 attributed this complexity to factors like identifying eligible services, understanding what was paid for the
13 services prior to the payment increase, and in some cases, identifying whether a provider had completed
14 self-attestation.
15 In the June 2013 chapter, the Commission highlighted the importance of a comprehensive
16 evaluation of the effect of the primary care payment increase, and ideally, this would use national claims
17 data, but we noted in that chapter that claims data wouldn't be available until after the provision had
18 expired. So in light of these data challenges, MACPAC conducted additional semi-structured interviews
19 with state Medicaid agencies, Medicaid managed care organizations, and provider organizations in eight
20 states. The states were Alabama, Kentucky, Michigan, Missouri, New Mexico, Rhode Island, Virginia, and
21 Washington state, and these interviews were conducted last summer between July and September.
22 In those interviews, interviewees reported to us that the operational challenges that were associated
23 with the initial implementation had largely been resolved at this point. So put another way, there were

1 some speed bumps they experienced in the initial rollout of this, but by the time we talked with them last
2 summer, things were operating fairly smoothly.
3 At the same time, they noted that payments to providers were initially delayed, although states made
4 retroactive payments to the providers. So provider orgs told us that this narrowed an already short time
5 frame that the provision was enacted for.
6 In four of the seven states we spoke with, the payment increase was implemented at different times
7 between the fee-for-service program and the managed care program, and providers found this confusing.
8 States and managed care organizations reported the payment increase had a best a modest effect on
9 provider participation. Some states saw an increase in provider participation. The numbers of providers
10 that were participating in the program had increased, but the states that told us that they saw this interpreted
11 these numbers cautiously. They said that there were other factors at play, things like the Medicaid
12 expansion or other state efforts to increase the primary care services or increase access to primary care
13 services.
14 Additionally, states unanimously reported that few physicians who completed self-attestation were
15 new to the program.
16 States reported that quantifying the amount of the additional payments to providers was challenging.
17 They had an easy time telling us on a per-code basis how much this meant or how much they paid out in
18 total, but they weren't tracking this on a per-provider basis, so they had a difficult time telling us, quantifying
19 how much of an impact this had on a provider level.
20 In addition to the work commissioned by MACPAC, early research is mixed on whether the
21 payment increase had an effect on access to care. Some research shows that providers increased their
22 Medicaid patient load or their providers' willingness to see new Medicaid patients increased.
23 For example, at our October meeting, we shared with you some preliminary results from a UPenn

1 Urban study, a secret shopper survey. That survey was released yesterday, and in it, they found that there
2 was an association between the payment increase and the availability of appointments for Medicaid
3 enrollees.
4 On the other hand, there's also some evidence that providers may not have been aware of the
5 provision, and this was particularly pronounced among small providers, small group providers, rather, in
6 individual practices. And there's some evidence that those who completed self-attestation were already
7 participating in the program.
8 Few states at this point have conducted their own evaluation, and ASPE has let a contract to do an
9 evaluation of the payment increase, but that's due out later this year.
10 So the chapter concludes with an overview of the rates in 2015, where we are today. Fourteen
11 states will continue to pay higher rates, although not necessarily at the Medicare level. One state that is
12 excluded from this number is Alaska, which was paying higher than Medicare prior to the payment increase,
13 and so they're going to continue to pay higher than Medicare-level rates, but I'm not including them in the
14 14 states for that reason.
15 And when we talked to some of the states that told us they were continuing to pay at the higher
16 level, they told us that although they couldn't quantify the payment increase, they felt that this payment
17 increase had strengthened their networks and improved the relationship between providers and the state
18 Medicaid agency. On the other hand, 24 states have reverted back to their pre-2013 levels.
19 With that, I will close. I look forward to your comments on the chapter.
20 CHAIR ROWLAND: I was just talking to Anne beforehand, and we thought, well, there's a
21 natural experiment here in those states that did the primary care payment rate. Katie can go and see what
22 did it do to the access to care, or those that maintain it, what happens there versus in the states that dropped
23 out. But then it will take us three years to get the results.

1 Okay. Donna.

2 COMMISSIONER CHECKETT: Well, I thought it was kind of sad that you thought this was a
3 post-mortem because I don't think this is over yet, and I know it's five and everyone is tired.

4 Actually, Ben, I think you did a great job. The report at this point, the chapter is very
5 straightforward. You have given us an update on something that we've discussed endlessly and wrung our
6 hands over what was Congress thinking and how are you going to administer it.

7 It is actually, I think, interesting to see that the states and the providers, for the most part, the
8 MCOs were able to work through some of the original administrative issues that so greatly concerned Dr.
9 Gabow, and that we were so fortunate, I think, to get an update. Particularly, the part that interested me
10 are the states that have decided to retain the increase and the states that have reverted to it. So I think it
11 will be interesting.

12 As Diane said, we'll be able to watch and track and see do we really have a difference in provider
13 participation.

14 I think, obviously, a question to the Commission is, do we want to continue to track this or not?
15 That is something for us to look at.

16 Then I guess I would just close my kind of kickoff comments with an observation that I wish that
17 provider participation was as simple as getting a rate increase, and I think in a context of such a changing
18 health care environment, certainly the biggest changes we've had in a long time, some of the discussions
19 from the new Commissioners about the fact that we have fewer providers being in independent practices, at
20 one point that starts to make things like a PCP bump actually not matter.

21 So I am not actually ready to close the doors, my own recommendation on it, and I just think, again,
22 as we look at access issue, to remember that an increase in payment, unless huge, won't necessarily do what
23 I think the hope was here. But it was a good, straightforward summary.

1 CHAIR ROWLAND: And I do think it's important to remember that the states that are
2 continuing it are continuing it at their traditional match rate and not at the 100 percent federal, so there's
3 some state dollars in there.
4 Other comments? Peter.
5 COMMISSIONER SZILAGYI: Yeah. I'm new, so I didn't take part in all the prior discussions
6 that you must have had, but the researcher inside of me, I never would have thought that this primary care
7 bump, which was viewed as temporary by many pediatricians or family physicians or internists would raise
8 participation in Medicaid.
9 So the question that I think I would have asked is, what did you do with the money, and what did
10 patients get for the money, or what did health systems get for the money? Did you put it into care
11 management? Were there other things? Because as Donna said, there are so many other factors. ACOs
12 are forming all over the country, and that's the driving force. It wasn't really the primary care bump.
13 I thought you had a great presentation, and the chapter is very clear, but I am not so sure the
14 question was the right question. It may be that primary care got substantially better, but it wasn't measured
15 by participation in Medicaid. So I would actually favor some sort of continued look because of this natural
16 experiment.
17 CHAIR ROWLAND: And because it's also part of our charge.
18 Other comments?
19 [No response.]
20 CHAIR ROWLAND: Well, thank you, Ben, for this non-postmortem, and thank everyone for
21 their many contributions today.
22 We will open it up again for public comment, if there are comments to be made. A mic should be
23 delivered momentarily.

1 ### PUBLIC COMMENT

2 * MR. YAEL: Is it on?

3 Thank you. I am going to make this really short. First of all, let me say I know this is the
4 Medicaid and CHIP Access and Payment Commission, but -- and Amy alluded to this. You know, I have
5 moved around the health care field over my career. I was with nursing homes and assisted living facilities
6 for a while. I was with the chain drug stores for a while. I was with the safety net hospitals and all the
7 folks they work with in the 340(b) program for a while, but it was not until I got to the mental health
8 providers that I saw as much concern about the need to thread various financing mechanisms together.

9 I cannot impress enough how important it is for you to bring SAMHSA to the table as you examine
10 the behavioral health field. SAMHSA is involved in funding. SAMHSA is involved in setting standards.

11 Just a couple of weeks ago, both CMS and SAMHSA had two separate listening sessions on
12 proposals for regulations on how to implement the excellence in Mental Health Act Demonstration
13 Program. They coordinate some. They don't coordinate enough, and the standards they set are not
14 necessarily in compliance. But the mental health providers are as much concerned about what SAMHSA is
15 doing with them and for them and how they are paying them as they are about how Medicaid is paying them
16 and how they're governing them. You have to have SAMHSA at the table.

17 Thank you.

18 CHAIR ROWLAND: Thank you.

19 MR. SPERLING: Good afternoon. I'll be very brief. I am Andrew Sperling with the National
20 Alliance on Mental Illness.

21 I want to congratulate the Commission on the chapter on behavioral health. It is tremendous.
22 The staff has done a tremendous job on this. The discussion you had was very rich, substantive. We're
23 very encouraged by this.

1 A couple things in NAMI which I would comment on very, very briefly, and that is the issue of the
2 IMD exclusion, which we urge Commission to take on. It's very, very important.
3 Don't get bogged down in the false difference, especially with acute care. NAMI believes that
4 acute inpatient bed capacity is part of a continuum of care that's needed in community-based services. So
5 we don't get involved in any false debates on that.
6 We'd also call to your attention Section 2707 of the Affordable Care Act that created a
7 demonstration program that 11 states are now doing where federal financial participation is allowed for
8 acute inpatient care that meets the entire standard. We expect data to be coming forward out of CMS in
9 2015, late in 2015, preliminary data with the contractor that CMS hired to look at this. We'd call this to
10 your attention. I think it would really inform the work the Commission does.
11 We are very encouraged by this chapter. The staff has done tremendous work, and we look
12 forward to supporting what the Commission does. Thank you.
13 CHAIR ROWLAND: Thank you as well.
14 Any other comments?
15 [No response.]
16 CHAIR ROWLAND: Then we will stand adjourned until tomorrow morning. Thank you all
17 very much.
18 * [Whereupon, at 5:04 p.m., the meeting was recessed, to reconvene at 9:15 a.m. on Friday, January 23,
19 2015.]

Medicaid and CHIP Payment and Access Commission

PUBLIC MEETING

Hall of States
National Guard Association of the U.S.
One Massachusetts Avenue, NW
Washington, D.C. 20001

Friday, January 23, 2015
9:22 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
SHARON L. CARTE, MHS
DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
GUSTAVO CRUZ, DMD, MPH
PATRICIA GABOW, MD
HERMAN GRAY, MD, MBA
MARK HOYT, FSA, MAAA
YVETTE LONG
NORMA MARTINEZ ROGERS, PhD, RN, FAAN
CHARLES MILLIGAN, JD, MPH
PATRICIA RILEY, MS
SARA ROSENBAUM, JD
PETER SZILAGYI, MD, MPH

ANNE L. SCHWARTZ, PhD, Executive Director

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1 P R O C E E D I N G S [9:22 a.m.]

2 CHAIR ROWLAND: Good morning, and it's great to welcome Michael and Lauren to our
3 meeting this morning to hear the results of the AcademyHealth Listening Project. I think, Anne, you were
4 going to introduce them.

5 EXECUTIVE DIRECTOR SCHWARTZ: Yeah, I just wanted to mention that some number of
6 months ago, AcademyHealth's Medicare Listening Project report came across my desk, which I read with
7 interest, and it prompted me to pick up the phone to say, "Well, I think it would be great if you did
8 something like this on Medicaid," to which Michael responded, "Well, we're already working on that.
9 We're way ahead of you." And we were pleased to be able to provide a little bit of money to be able to
10 enhance the number of interviews that they were conducting so that even they could great a broader range
11 and a deeper range of interviews in this project.

12 But this project is AcademyHealth's, and we are delighted for them to come here and share their
13 findings with us.

14 ### **Session 8: MEDICAID LISTENING PROJECT**

15 * MR. GLUCK: All right. Thank you. I first want to thank you all for giving us the opportunity
16 to present this work. I'm going to give a little bit of context and tell you a little bit about how we went
17 about this work. My colleague Lauren Radomski is going to tell you a little bit about what we found, and
18 then I'll have a few comments, just concluding remarks. And I also just want to acknowledge Samantha
19 Smith, who's sitting over here. She and Lauren were really the folks who did most of the bulk of the work
20 here, and I just wanted to acknowledge here.

21 So as Anne said, this is part of our Listening Project. There we go. The Listening Project is an
22 initiative of AcademyHealth's Translation and Dissemination Institute, and the institute is two years old, and
23 we say we're about the art and science of getting health services research -- making it more usable and

1 getting it used. The Listening Project is premised on the idea that the first step in that process is helping
2 researchers work on the right topics.
3 I also just want to mention I'm going to -- we both are going to be using the term "research"
4 throughout the presentation, and we mean that very broadly. There may be times when we're specifically
5 referring to academic research, but we really are using the term to refer to evidence that can -- rigorous,
6 relevant evidence that can inform policy.
7 In this report, we sat down with Medicaid policymakers, and we asked them to look three to five
8 years into the future and to tell us what were their most pressing researcher evidence needs. Anne alluded
9 to the project that we did last year focused on Medicare. We have another one underway that has a slightly
10 different focus. We're sitting down with the folks who -- the leadership within safety net provider
11 organizations to hear a little bit about how they think about evidence to inform innovation on the clinical
12 side.
13 The report today is focused on Medicaid, and in addition to your funding, it was supported by the
14 Robert Wood Johnson Foundation.
15 I also just wanted to mention, before I get into who we talked to, just mention who we didn't talk to.
16 Even though there is a significant amount of Medicaid expertise around this table, we consciously didn't
17 speak to any of you for this report or to the staff because we wanted to keep the work independent of the
18 conversations that you've already been having on these issues.
19 So turning to who we interviewed, we conducted a total of 53 interviews with policymakers,
20 stakeholders, and other experts. The terms of our IRB exemption for the research require that we keep
21 the names of the people that we talked to anonymous, as well as the specific organizations that we talked to,
22 but we wanted to give you a little bit of a flavor of the diversity of perspectives that we had represented.
23 The top of this chart, this table, tells you a little bit about where people work. A little over half of

1 the folks were employed either by the federal government or by national organizations that are interested in
2 Medicaid policy across the states. This included provider organizations, trade associations, national
3 organizations of state officials, and consumer advisory groups.
4 The remaining interviewees are policymakers in state government, researchers who are focused on
5 state health policy, or others who are interested or have an interest in Medicaid within specific states. They
6 also represent a wide -- it's not up here, but we have a wide set of geographic locations that were
7 represented and different -- you know, where relevant, different political perspectives.
8 Also, just to give you a flavor, we had a wide range of expertise in the group, and these included
9 expertise on specific populations, on specific ways of delivering Medicaid care, as well as more general
10 expertise on quality, cost, access, and disparities.
11 Go to the next slide. So we did the interviews, and this slide just tells you a little bit about how we
12 went about doing the analysis. We had transcripts -- we had the interviews transcribed, and we used
13 standard qualitative research methods to code the transcript and identify key themes across the interviews.
14 Two of us independently coded each interview, and then we sat down to work through discrepancies.
15 From there we prepared a draft report. That we had reviewed by an outside committee of some people we
16 had interviewed as well as a number of other experts on Medicaid, and based on their comments, we revised
17 the report, and that's what we're presenting to you today.
18 So a little bit about the structure of the report. It's divided into four sections. This morning,
19 we're just going to focus in this presentation on the first two sections -- gaps in research and gaps in data
20 that we heard about. The other two sections, if there's interest, in the Q&A we're happy to tell you a little
21 bit about what we learned about how these folks help Medicaid policymakers say they use evidence and the
22 advice that they have for researchers who want to do relevant research on the topic.
23 And with that, I'm going to turn it over to my colleague Lauren.

1 * MS. RADOMSKI: So as Michael mentioned, really the key question that we asked in the
2 interviews was: What are some of the key issues where new or better evidence could help inform Medicaid
3 policymaking over the next several years. And, not surprisingly, nearly everyone we spoke with identified
4 Medicaid expansion as a key issue facing policymakers now and into the foreseeable future.
5 We heard a lot of interest in the impact of expansion on state budgets and on health outcomes.
6 We heard a lot of interest particularly in alternative approaches to expanding Medicaid, so, for example, the
7 premium assistance models in place in Arkansas and Iowa. We heard some questions there about what are
8 the impacts of these models on enrollee costs, state budgets, service utilization, and health outcomes.
9 A number of people we spoke with, particularly those in state government, were very interested in
10 having comparative information from states that have chosen to expand and from states that have chosen
11 not to expand at this time.
12 And a number of folks made the comment that this type of information is going to be really crucial
13 over the next several years as state policymakers look to the experiences of other states and potentially
14 revisit the decisions that they've made so far.
15 Also on the topic of Medicaid expansion, we heard a lot of questions about the health status and
16 health-seeking behavior of individuals who are newly eligible for coverage, for example, questions about the
17 baseline health status of this group, the size of the group, and their use of preventive care and other
18 services.
19 Payment and delivery system reform was another topic that came up quite a bit in the interviews.
20 Across the interviews we heard significant interest how states might be better purchasers of health care
21 services, particularly in their relationships with Medicaid managed care plans. We heard a lot of interest in
22 how states might structure payments to plans in a way that helps improve quality, control costs, and will
23 ultimately drive value.

1 We did hear that states continue to struggle with assessing plans' quality performance, and a number
2 of people suggested that the development of better quality metrics that really go beyond process measures
3 to get at outcomes could be an important starting place for implementing value-based payment.
4 We also heard a number of comments about accountable care organizations, medical homes, and
5 other initiatives that aim to provide more coordinated care for Medicaid enrollees at lower costs. And
6 really the big question here was: What works? And a number of interviewees suggested there may be a
7 role for the research community in highlighting what kinds of interventions are effective for which
8 populations and why.
9 This interest in really drilling down to the needs of specific Medicaid populations was also a theme
10 that emerged in the interviews. Respondents told us they were very interested in targeted strategies for
11 serving enrollees with complex health care and social services needs, such as dual eligibles, individuals with
12 mental illness and substance use disorders, and children with special health needs. And here we heard a
13 number of questions about how to match people with the right set of services delivered in the most
14 appropriate setting and by the right type of health care professional. And people we spoke with indicated
15 that information that helps policymakers make those kinds of determinations would be useful.
16 We also heard a number of comments about the move of many high-need populations into
17 Medicaid managed care and a real interest in knowing how well managed care is working for these groups
18 and how managed care compares to fee-for-service in terms of access, cost, quality, and the patient
19 experience.
20 We identify a number of other research needs in the report that I'm just going to touch on here.
21 We heard a number of questions about effective strategies for enrolling individuals in coverage and retaining
22 people. We also heard a number of comments about the need for strategies that help incentivize enrollees
23 to be more active in their own health, engage in behaviors that can help improve their health, and also

1 potentially reduce program costs. And an interesting line of comments that emerged here as well was a
2 real interest in knowing how well enrollees understand their coverage and cost-sharing requirements,
3 particularly in those states that are experimenting with new cost-sharing models as part of their Medicaid
4 expansions.
5 Benefit design came up in a number of conversations, particularly in relation to coverage of
6 behavioral health services, high-cost pharmaceuticals, and also around the health needs of newly eligible
7 individuals.
8 Behavioral health also emerged as an area of significant interest. Again, we heard this question of
9 how do you identify the right types of services for people with varying types and severity of mental illness.
10 We heard some interest in the potential cost-effectiveness of utilizing community health workers, care
11 support specialists, and other types of health care professionals in delivering behavioral health services,
12 particularly in those areas where there may be workforce shortages. And we did hear quite a bit about the
13 need for cost-effective strategies for integrating physical health and behavioral health services.
14 Beyond behavioral health, we heard a lot of interest in how services and systems that serve Medicaid
15 enrollees might be better integrated or coordinated, for example, social services, public health, the
16 interaction with the criminal justice system; and some of the comments that we heard on this topic kind of
17 addressed the potential for Medicaid to cover supportive housing, employment assistance, and other types
18 of services that could help address social determinants among Medicaid enrollees.
19 And last, but certainly not least, we heard a number of comments about access to care, some
20 concerns about enrollees' ability to access care, especially specialty providers, questions about are there
21 sufficient providers, are they the right types of providers, and also some questions about the impact of the
22 primary care payment increase on people's access to care.
23 In addition to asking about gaps in research or evidence, we also asked about data needs. We

1 know that the limitations surrounding Medicaid data are pretty well recognized and expect that these will be
2 familiar to you. We heard a number of comments about the complexity of Medicaid data, the kind of
3 messiness that can make it difficult for researchers and product analysts to make sense of Medicaid data to
4 be able to use it to help it inform policy decisions.
5 A theme that came up across the interviews was a real interest among states in learning from the
6 experiences of other states, and the need for more comparative information came up quite a bit. People
7 recognized that differences in data reporting and collection practices can mean that folks who are doing a
8 multi-state analysis may need to go to each states individually for data, which is a time- and
9 resource-intensive process not only for the researcher analysis but for the people in state government who
10 might be helping the researcher get that data.
11 We also heard a lot of interest among states in particular for more detailed encounter data from
12 managed care plans. They noted that while plans do have reporting requirements to states, states are very
13 interested in getting as detailed as possible as they try to monitor care at the individual level, identify trends
14 in utilization, and track access to care for certain populations. And these comments really reflected a
15 broader theme that we heard in the interviews about kind of a lack of understanding of how managed care
16 plans work on the inside. So, for example, we heard a comment about how does a payment from a state
17 move through a plan and is disbursed to providers, and what does that process mean for the care that an
18 enrollee receives?
19 We heard similar comments about accountable care organizations and medical homes. One person
20 questioned what is in the secret sauce of medical homes. And these comments were very similar to ones
21 we heard in the Medicare-focused report about trying to understand the workings of Medicare Advantage
22 plans.
23 And we also heard quite a bit about measurement in different contexts throughout the interviews.

1 As I mentioned previously, quality measurement came up quite a bit, particularly in regards to payment
2 reform. But we also heard a lot of interest in trying to assess the quality of care received by populations
3 with complex needs.
4 We also heard some about measurement issues related to measuring access to care. In this quote,
5 someone raises the point about the need for better measures that incorporate the other ways that people
6 may receive care, such as through telehealth, that may not be directly in a physician's office.
7 We also heard some interest among states in better measures that they might use to try to assess the
8 extent of access challenges in their states.
9 And so with that, I'll turn it back to Michael for some wrap-up comments.
10 MR. GLUCK: So, this slide just summarizes what you just heard, and we can leave it up there for
11 discussion in case that would be useful.
12 I just wanted to say in the end that we envision this project -- these projects, these reports -- rather
13 than being ends in themselves as the starting point for a conversation among researchers, funders, and the
14 users of that research, in this case, Medicaid policy makers, and we hope it will be sort of an ongoing
15 conversation. We are doing that through a number of traditional means for some of the AcademyHealth,
16 other programs.
17 But, we have also launched a new product and want to continue to try doing new things. This new
18 product, we are calling Evidence Road Maps, and we have released nine of those from our Medicare report.
19 We plan to do them for this report, as well. And, they try to get at the question of whether these gaps,
20 these perceived research and data gaps, represent a real lack of evidence or whether, to some extent, it might
21 be a failure to translate and disseminate what's already out there.
22 So, with that, I will end and welcome your questions.
23 CHAIR ROWLAND: Thank you very much.

1 I'll start with Patty, then Trish.

2 COMMISSIONER GABOW: Thank you. This is interesting. I have four questions.

3 CHAIR ROWLAND: You usually have three.

4 COMMISSIONER GABOW: And one is -- I'll just quickly list them. One is, did you hear any

5 concerns about the need for simplification of this program in order to make it easier to administer and

6 easier for our patients to access?

7 The second is, because Medicaid is not one program but 56 programs, did you hear any concern

8 about the fact that where you live in America can greatly influence both access and quality of care, and was

9 there any concern about creating more uniformity to this program, similar to the uniformity in Medicare?

10 And, one of the things we've heard a lot about on this Commission is the states' capacity to

11 administer such complex programs. One of our persons who came here talked about if any of these

12 programs were independent companies, they'd be Fortune 500 companies, but the staffs that they have at

13 state Medicaid is certainly not either the number or the skill set of a Fortune 500 company. So, did you

14 hear that?

15 And, finally, I'd be interested in what you heard were the main differences in your Medicare

16 Listening Project and your Medicaid Listening Project.

17 So, you can start anywhere.

18 [Laughter.]

19 MS. RADOMSKI: To your questions about simplifying the program, you know, we didn't hear

20 any comments on that in particular. We heard a number of comments that were just kind of reflecting on

21 the fact that Medicaid is such a huge part of state budgets and that the decisions that are made about

22 Medicaid have implications for other areas of spending in state governments, education, other things that

23 are affected by the amount of resources that go to Medicaid.

1 You know, in terms of the -- I think there was a recognition about the differences, of course, in state
2 Medicaid programs, and as you say, the fact that where you live can really influence your access and the care
3 you receive. But, we didn't hear folks call that out in particular.
4 We heard about state capacity, some in our questions about policy makers' use of evidence. People
5 mentioned that one of the factors that influences the ability of policy makers to use evidence to inform
6 policy decisions is the fact that people really are so pressed for time and resources and that there are just
7 many constraints that researchers should be aware of in order to be good research partners, that they're
8 looking to do research with states.
9 CHAIR ROWLAND: And, on Medicare versus Medicaid.
10 MR. GLUCK: Yeah. So, Lauren alluded to some of the ways, some of the similarities that we
11 heard, particularly about sort of looking into the black boxes of these newer ways of delivering care.
12 But, in terms of differences, they really all go back to, basically, the difference between Medicare and
13 Medicaid and having 56 programs versus a national program. We heard a lot more about the difficulties,
14 the challenges that politics can play in policy making. There just was much more attention to that. There
15 was, as Lauren said, a lot of interest in looking at what other states are doing, just by the nature of the
16 program. We didn't hear a lot of folks say they wanted to look, I don't know, at other countries to figure
17 out how to administer Medicare [sic].
18 We also, when we asked people what advice they had for researchers who wanted to do
19 policy-relevant work, some of the things that we heard were what you often hear about the importance of
20 personal relationships, writing clearly and concisely and being timely, but we did hear two things that were
21 different. The first was this need to stress -- the importance of context. We didn't hear a lot about the --
22 we didn't hear a lot about that. So, in this -- in the Medicare report, that is. In this report, we heard a lot
23 of comments around the importance of particular state circumstances and whether it had to do with the

1 population, the nature of the marketplace, the politics and sort of philosophical bent of the state.

2 The other thing we heard, which it's harder to sort of attribute it to some differences between the

3 programs, is there was much more talk about the importance of placing -- of researchers being able to put

4 their studies within the context of the broader literature. How does this study differ from what's already

5 out there? And, there was a real desire, and even some people mentioned the value of systematic reviews

6 and anything that can help them absorb a body of literature rather than particular studies. To my mind,

7 there's no reason why we shouldn't have heard that in the Medicare reports, but we didn't.

8 CHAIR ROWLAND: In terms of the people you interviewed, some of them were researchers, or

9 -- is that what you meant by non-government experts?

10 MR. GLUCK: Yeah. Yeah. And, for the most part, they were researchers that either had some

11 -- had stronger ties than your average academic to the policy world. Either they have worked in

12 government or they were in -- they weren't necessarily in universities.

13 CHAIR ROWLAND: And, were some of them the same researchers you interviewed in the

14 Medicare project, or different researchers?

15 MR. GLUCK: I don't think there was any overlap --

16 MS. RADOMSKI: I don't believe we had any overlap.

17 MR. GLUCK: Yeah.

18 CHAIR ROWLAND: Because, I would wonder --researchers who work on Medicare would have

19 a very different perspective on data and data availability --

20 MR. GLUCK: Yeah. Yeah.

21 CHAIR ROWLAND: -- than researchers who work on Medicaid, and that I would assume that

22 would be a big difference between the two programs. I mean, there is a current beneficiary survey and a

23 lot of other ways to really dig into the Medicare program that we struggled with a little bit because Medicaid

1 does not have such a national database.

2 MR. GLUCK: And, one place where we did hear similar concerns was the challenges of using and

3 getting -- getting and using encounter data and for managed care.

4 CHAIR ROWLAND: I had Trish next, and then --

5 COMMISSIONER RILEY: Thank you. This is really interesting. But, sort of keying off

6 Diane's question, our major constituency is state and federal policy makers. Can you cut the data by state

7 and federal policy makers, or do you know that there are differences in the findings based on where people

8 sit?

9 MS. RADOMSKI: I can just say that one of the things that we tried to do in the report, as Michael

10 mentioned, we use a lot of unidentified quotes in the full report to kind of highlight our key findings

11 because we feel like that was a good way to kind of present that information, and we try to provide some

12 context to say, you know, this type of person raised this issue so that it's a little clearer, the types of things

13 that we heard from state policy makers versus federal, someone who might be in a researcher role, so that

14 it's a little clearer who said what without identifying who that person is.

15 [Off microphone comments.]

16 MR. GLUCK: I mean, theoretically, if I were going to generalize, I would say for all the

17 respondents, but particularly for policy makers, there was sort of a, maybe a little bit of a kind of immediacy

18 bias, so, what's on my plate today, what do I need to worry about next week. And, I think some of that

19 played through in the comments people made about the role of state budgets and the state budgeting

20 process. So, we heard more of that from policy makers than from researchers.

21 CHAIR ROWLAND: Okay. I have Peter. I have Chuck. I have Gustavo. And, I have

22 Mark.

23 COMMISSIONER SZILAGYI: This is very interesting. Actually, I had a very similar question

1 to what you were just talking about, Michael. Everybody now has a tension between making system
2 changes that may affect things right away versus significant system changes that will have long-term lifespan
3 type of impact. And, what did you hear in terms of what people want in terms of short-term --information
4 that will help them in the short term versus information on serious system changes that will help them for
5 the long term? And, this kind of affects both the research or the data or, potentially, the transformations
6 that people are talking about.
7 MS. RADOMSKI: That's a great question, and that's something that we were talking a little bit
8 about, actually, in getting our comments for today, really, a recognition that there are kind of policy analysis
9 projects that are maybe conducted in a little bit more shorter time frames that produce information that
10 folks could use to inform decisions in the short term and maybe longer research projects to inform
11 decisions over time.
12 I think, definitely, the issues around expansion seem to be more pressing. Those came up as an
13 area where people were quite eager for information in the short term. But, I think I would probably have
14 to go back and kind of take a closer look at the report with that lens and maybe get back to you on what
15 folks said there.
16 MR. GLUCK: You know, and you can correct me if you think differently, but I -- there was very
17 little discussion that I remember of sort of long-term, big picture restructuring of Medicaid. It really didn't
18 go sort of beyond -- that I remember the conversations -- about whether to revisit expansion decisions.
19 On the Medicare side, there was a little bit more of that and it usually came from people who had a
20 particular philosophical bent. Is that --
21 COMMISSIONER SZILAGYI: The corollary, not just the long-term restructuring of Medicaid
22 but bending the curve of health outcomes for this population, whether or not that's Medicaid or research
23 that's related to Medicaid and the world beyond Medicaid.

1 MR. GLUCK: I think a lot of that played out in comments about wanting to know what works
2 best for specific populations. How can we best provide care that's going to improve health outcomes,
3 lower costs, eliminate disparities.
4 CHAIR ROWLAND: Chuck.
5 COMMISSIONER MILLIGAN: This is helpful work. I'm going to do a little bit of background
6 before getting to my questions.
7 So, I was Maryland's Medicaid Director for a little bit more than three years, until fairly recently, and
8 before that, I was seven years at the University of Maryland Health Services Research Center. And, I think
9 one of the -- so, this is very good in terms of identifying needs on data sources. I think I want to just raise
10 a couple of barriers to getting to this point from having been in versions of both sides of this.
11 The part of the context that gets to the Medicaid administrative agency capacity is state Medicaid
12 agencies are just unbelievably inundated with requests. I mean, you cannot imagine. And, there's the
13 requests that you have to respond to because CMS is sending something, or the federal OIG is sending
14 something, or CBO, or the Hill, or all that kind of stuff. But, the researchers who are being funded from
15 philanthropic organizations or HRSA or NIH or others, I used to get probably three to five a week asking
16 for staff time, asking for data. And, the burden is pretty staggering. So, I think that there's a bandwidth
17 issue that is part of the context here that I think is important to raise.
18 There's a second level issue, which is there's a tension not only in the timeliness piece of it, I think,
19 which is kind of inherent in some of this, but there's a tension between an academic model -- which I
20 respect and value and used to work with the university, as I said -- of academic freedom, publishing,
21 dissemination, transparency, you know, the greater good, and a state agency and stakeholders in state
22 agencies and state government who are operating in a political world, and that having comfort giving data,
23 making staff available, not knowing how it's going to be used and how it will then play out in a state

1 legislative session or a Governor's budget is a barrier, and there's a tension between those pieces of it.

2 And, I do think the other part of it -- and this is also inherent in the nature of it -- is a lot of

3 evaluations and data and work that happens here, the programs have changed in the interim because of -- I

4 mean, every -- cost sharing rules change, waivers change. The states are sort of working off of bad data

5 and political considerations all the time. And, so, a lot of times, evaluations are really beautiful for a

6 program that six months ago really wasn't what the state was running anymore. And, so, I just -- I think

7 that -- I'm offering that not because -- as critically. I think this is great work. But, the context of how to

8 then address getting the research out and the data out and dealing with state bandwidth issues will make the

9 next phase of all of this difficult. So, I just want to raise those considerations.

10 MR. GLUCK: Yeah. Those are both -- they are all three, actually, great points. The first two,

11 the state capacity issue and the issue of agency, they're both addressed in the report. We didn't talk about

12 them here.

13 On the agency, the state agency and academic freedom, we heard a number of comments about --

14 among state policy makers about a preference for consultants over researchers for a lot of those reasons,

15 and the capacity issue came up repeatedly.

16 MS. RADOMSKI: I guess one comment I would just add is that we did hear some comments

17 from policy makers that the type of information that they need, the kind of quick turnaround, say, to inform

18 a budget, may not be information that gets the researcher a journal publication, for example, but it's

19 incredibly helpful to them in informing their internal discussions.

20 COMMISSIONER MILLIGAN: Yeah, just, there were a number of times we needed stuff over

21 the summer and could never find the researchers who were working on that.

22 [Laughter.]

23 CHAIR ROWLAND: Okay. Gustavo, then I have Mark, Sharon, and Sara.

1 COMMISSIONER CRUZ: Thank you. Thank you for your presentation. I would be
2 interested to hear a little bit more about the service coordination, integration, the research needs. It is very
3 refreshing to hear them acknowledge the social determinants of health and how they need to work
4 collaboratively with other agencies. Were they mostly sort of talking about demonstration projects that
5 may be funded by the federal Government or sort of a dissemination of innovative models that already exist
6 someplace else --
7 MS. RADOMSKI: So in terms of the service organization or integration piece, part of where that
8 came from was, as people were talking about the need to try to match and release with the right types of
9 services, they were really interested in getting a complete picture of the services that a person is receiving
10 across different systems.
11 And we did hear some people, as I said, express an interest in might there be a role for Medicaid in
12 providing, say, supportive housing or employment assistance, but we did not hear that from everyone.
13 Some people spoke very passionately. One person in particular who talked about issues such as
14 unemployment, lack of educational attainment, as being health issues, but ones that we have not traditionally
15 thought about as being health issues and that those were important to address as part of health, at the same
16 time we did hear some reservations that really until there are financial incentives in place for states to do
17 those kinds of things, that there may not be much movement in both states.
18 COMMISSIONER CRUZ: Very difficult to break down those silos.
19 CHAIR ROWLAND: Mark.
20 COMMISSIONER HOYT: I wondered what kind of bar you had to make it up until the list of
21 needs. Did half the people ask for this? Was this like unanimous?
22 Then I had a follow-up question, which was did you -- or are you going to ask them, "So what are
23 your suggestions on how to address the needs"?

1 MR. GLUCK: Nothing was unanimous, and there's -- in this judgment call in this, it's qualitative
2 research. There's always the possibility that some of what we heard depended on who we talked to.
3 We tried to identify themes, and they were expressed sometimes with different words and in
4 different ways.
5 The things that made it on the list, they definitely jumped out from the work. There were a
6 number of other very specific -- and other comments that aren't on this list, but they weren't -- they might
7 have been mentioned by one person.
8 MS. RADOMSKI: There are some times in the report where there may have been something
9 mentioned by only one person, but we thought it was pretty interesting, so we included it. But we noted
10 that it was one person's comments.
11 Also, to your question, we, as Michael mentioned, talked with people with a real range of expertise
12 on different populations, different issues within Medicaid, but there were certain topics that really rose to
13 the surface across the interviews, regardless of the person's particular focus. And that's what we've kind of
14 captured here in our big eight, that we try to bring out some of those other more specific ones in the report.
15 COMMISSIONER HOYT: Okay. Then what about what's your idea on how to fix this? Like
16 the comment about encounter data, is that new, so did they make suggestions on what we should do
17 differently to meet that need?
18 MS. RADOMSKI: That's a good question.
19 MR. GLUCK: Specifically, I don't remember any particular suggestions on the encounter data.
20 These things were more an expression of need in part because that's what we asked them. We didn't
21 necessarily ask them how to fix a problem.
22 Some of it came out a little bit when we asked the informants what advice they would have for
23 researchers or how would you go about doing work on these topics, but there, it was more focused on the

1 research process and less on the particular topic.

2 CHAIR ROWLAND: Mark, maybe it's our job to figure out how to fix them.

3 Sharon.

4 COMMISSIONER CARTE: In light of some of the comments that Chuck made about barriers,

5 which really are a reflection of the highly dynamic environment that we're in now, it just seems like the

6 focus on data needs, as almost a prequel to being able to produce research, should be given a more

7 prominent focus.

8 I'm in a CHIP program, and even as I look at how states struggle just to get -- to tedious pull, get

9 our claims data and look at it, when I think of the child population is the largest percentage of the Medicaid

10 enrollees, and then the need for things like the encounter data, it seems like it has to take a precedence if we

11 really want to have meaningful research and that informs -- clearly informs these areas. And I don't know

12 how that gets elevated or asking for the commitment from policymakers to put that up there.

13 MR. GLUCK: I will answer this from my seat at Academy Health. Some of our colleagues,

14 specifically those who work in our state-facing programs, a lot their emphasis is really in trying to build, to

15 help some of the state-based health policy centers and also just improve the capacities within the states.

16 And they're thinking about a number of different ways of doing that.

17 Data seems to be a perennial issue across policy and health services topics, and there are a number

18 of other programs at Academy Health that are addressing that in various ways.

19 COMMISSIONER CARTE: Well, I think I am thinking about jumping to a whole other level

20 where MSIS would help that data be available, where the states don't have that capacity, and we could take

21 more of a quantum leap.

22 CHAIR ROWLAND: Okay. Sara.

23 COMMISSIONER ROSENBAUM: I have to ask, were there any topics that came up where

1 people said we don't need more of this research? I mean, for example, do we need another study showing
2 that if you give Medicaid to a lot of poor people, your uninsured rate comes down?
3 [Laughter.]
4 COMMISSIONER ROSENBAUM: Or if you give Medicaid to people, they use more health care?
5 That is not to disparate the great landmark studies that have come out of these issues. They are very
6 important, and I cite them all the time, but it goes to this question of people feeling that there are certain
7 questions that have been asked and answered.
8 So in terms of prioritizing, it's not just the points that have been raised, certain populations, short
9 term or long term. It's sort of trying to get at things that we don't know and not feeling as if every three
10 years a new generation of skeptics has to have more research done that Medicaid brings down your
11 uninsured numbers.
12 So any light you can shed on that would be great.
13 MR. GLUCK: We heard, I think, more along those lines in the Medicare interviews that we did
14 last year, a lot of frustration with research that seems to confirm things we already know and people not
15 working on the things that policymakers really care about now.
16 Do you remember anything specifically from the Medicaid?
17 MS. RADOMSKI: No. I don't recall anything coming up real consistently in the Medicaid
18 interviews about this is something we have enough of or it's been established.
19 CHAIR ROWLAND: Sara, if they want more on expansion versus non-expansion states, they
20 want those same studies over again?
21 COMMISSIONER ROSENBAUM: Yeah. I mean, it would be a great thing if we could take this
22 information and what you found that people want and really map it against --
23 CHAIR ROWLAND: What we know.

1 COMMISSIONER ROSENBAUM: Against what we know, so that as a Commission, we are
2 really honing in on those questions that we should be focused on, not to belittle any question that gets
3 asked. But there are things we need to know about the newly eligible population for sure, but I don't think
4 we need to know that if you give people coverage, they are going to get access to care.
5 CHAIR ROWLAND: I guess one question is, in all of this, there is more and more discussion
6 about personal responsibility, about what level of cost sharing people can bear. Was there any discussion
7 of trying to get a better way to measure affordability or at what point does personal responsibility create a
8 barrier to care?
9 MS. RADOMSKI: I don't know that we heard people necessarily mention personal responsibility
10 explicitly, but we did hear a number of comments about -- questions about how well people will be able to
11 afford coverage over time and questions about new models of cost sharing, how do people respond to
12 those, do people simply change their utilization of services in response to those. So we did hear some
13 comments on that issue of cost sharing and what does increased cost sharing mean for people's usage of
14 services.
15 MR. GLUCK: Tangentially related to that was the desire for better measures of access.
16 CHAIR ROWLAND: Andy.
17 COMMISSIONER COHEN: I'm curious whether -- and this is something, this is maybe outside
18 of health services research, but bears on health services -- whether people talked at all about more research
19 into -- I'm going to use a term that's a little bit, maybe faddish right now, but like behavioral economics, and
20 sort of like what motivates both patients or consumers to change their behavior, which maybe goes to the
21 personal responsibility side, but also the question of what are the policy and payment changes that motivate
22 providers and systems to change. Do you know what I mean? So it's sort of like a little bit of
23 organizational dynamics and behavior economics and those kinds of questions, and I know they're

1 obviously bigger than Medicaid, per se, but when you're trying to think about system transformation, what
2 actually motivates people and organizations to change and the combinations of things you can do? Was
3 that a theme that came up?
4 MS. RADOMSKI: The one comment that we heard that was more on the consumer side was
5 what motivates consumer behavior, consumer behavior change.
6 I can't recall comments on the organization side or on the provider side quite as much, other than
7 we did hear kind of the perennial concern about provider payment and how might that affect people's
8 access to care and willingness to take Medicaid.
9 CHAIR ROWLAND: Well, I think it's regarding to us that while you didn't interview any of us or
10 the staff, your recommendations and our observations came fairly close to the overall framework of what
11 we think we should be working on and what we think the key issues are. So it's always rewarding to have
12 someone validate where you're going, and we appreciate your joining us today to share the report, which will
13 officially be out in February, I understand?
14 MR. GLUCK: I believe it is actually -- officially, it's available on the website now, and you have
15 copies of the Executive Summary. There's a link in there to the full report, so you can get it. I think
16 we're not going to do any promotion of it for a couple of weeks, just because of a few other things that
17 Academy Health has in the works.
18 CHAIR ROWLAND: But can talk about it already?
19 MR. GLUCK: You can talk about it, yeah.
20 CHAIR ROWLAND: Thank you.
21 MR. GLUCK: Thanks.
22 CHAIR ROWLAND: And now we're going to return to the land of CHIP, and Joanne is going to
23 join us to really review -- as you recall, we decided after the last meeting to try and reach out more directly to

1 some of the stakeholders to see, given our continued work on CHIP, what some of the stakeholders would
2 want to be sure we were taking into account in our work, and Joanne is going to review that experience with
3 us. And it's Tab 10 of your briefing books.

4 ### **Session 9: FEEDBACK FROM CHIP STAKEHOLDERS**

5 * MS. JEE: Right.

6 So I am going to summarize for you quickly some of the feedback that we heard from the
7 November letter to CHIP stakeholders.

8 In November, MACPAC issued a letter to CHIP stakeholders requesting their input on a variety of
9 issues related to children's coverage in the exchange and some of their ideas for policy options for
10 addressing those issues.

11 The specific areas that we requested input on are listed on the slide here and really are consistent
12 with the policy goals that we have been laying out for you over the course of our several meetings.

13 The letter was sent directly to specific groups that we knew were involved in CHIP issues, but it also
14 was e-mailed widely to folks who received the MACPAC e-mails as well as on our website. So it really was
15 an open letter, and anybody could respond should they choose to.

16 This was the first time that MACPAC reached out in this sort of targeted fashion to stakeholders.
17 Our goals were really to obtain some substantive input but also to provide another avenue for public
18 comment, and this is in addition to opportunities for public comment at our meetings, through our website,
19 and through in-person meetings with the MACPAC staff.

20 To turn to the letters, we received 55 responses to this letter, including one national sign-on letter,
21 which was signed by 49 organizations, many of which also sent their own response. In addition to that
22 letter, we received responses from plans, providers, various other stakeholder groups as well, both at the
23 national and state levels.

1 Your meeting material includes three examples of the letters. The first is the national sign-on
2 letter, the second two represent a common model for many of the letters that we received. We found that
3 many of the letters were the same or very similar to the letters that are in your packet.
4 There is a complete list of respondents in your meeting materials, and if you'd like to read any one of
5 those letters, we'd be happy to provide them to you.
6 I also just wanted to mention quickly that many of the respondents took this opportunity to
7 comment on the Commission's June 2014 recommendation for the two-year CHIP-funding renewal, during
8 which time the issues related to coverage in the exchange for children could be addressed.
9 The majority of respondents thought the funding renewal should be longer than two years. Many
10 of them specifically stated four, and many were silent as to how long a renewal should be for.
11 So as we go through the responses, you'll see that the issues that were raised in the letters are really
12 very consistent with the issues that the Commission has already begun addressing. The first area that we
13 asked for comment on was affordability of coverage and out-of-pocket costs.
14 The slide lists the most commonly cited concerns among the respondents. I won't read through
15 them, but I wanted to just share with you some of the sort of ideas and policy options that they suggested as
16 ways to address these issues.
17 Many of the respondents suggested that exchange cost sharing should be comparable to CHIP. I
18 didn't really see specific recommendations on how to achieve that. There was one suggestion that
19 child-only plans with high actuarial values and relatively low premiums might be something to consider as
20 an offering on the exchange.
21 Affordability of dental coverage was commonly raised, and we talked a little bit about this yesterday,
22 but many respondents suggested that the subsidies, the cost-sharing reductions and the premium tax credits,
23 which are available on the exchange should either take into account the cost of dental coverage or should be

1 applied toward dental coverage.

2 Some thought that prohibiting the sale of stand-alone dental plans would be one way to ensure
3 access to pediatric dental coverage for children or requiring exchange plans to provide them within the
4 QHP, or the qualified health plan.

5 And children with special health care needs was raised throughout several of the letters across all of
6 the policy goal areas, and with respect to affordability, many respondents just noted that their affordability
7 concerns really needed to be taken into account within any sort of assessment of affordability.

8 So to turn to adequacy of covered benefits, again, the most commonly listed issues are provided for
9 you on this slide. Respondents suggested that benefit adequacy issues could be addressed by establishing
10 pediatric standards for essential health benefit benchmarks. Some suggested using CHIP or EPSDT as
11 that standard. And with respect to improving adequacy for children with special health care needs, some
12 thought that defining habilitating services would be important to that.

13 With respect to adequacy and appropriateness of provider networks, the concerns are on this slide
14 again. Some respondents urged that a standard that assured access to the full range of pediatric primary
15 specialty and subspecialty providers was needed. Others thought that pediatric specialists and
16 subspecialists should be deemed as essential community providers.

17 Narrow networks was raised by respondents, and, again, many thought that requiring the provision
18 of a full range of pediatric providers would be important and that a standard would, you know, help to
19 accomplish that.

20 Others urged that ensuring that children have access to providers that they need, even if those
21 providers are out of network, would be important, just noting that sometimes those needed providers were
22 not available within the network.

23 Some respondents noted that assessing adequacy of exchange networks was difficult, in some part

1 due to data on those networks and in some part due to not having a standard against which to judge that
2 network. So, again, you know, these are issues that probably sound very familiar to you based on
3 yesterday's meeting.
4 We asked stakeholders to comment on key concerns with transitions between sources of coverage.
5 Again, the primary concerns that were listed are on this slide. With respect to continuity of care, some
6 respondents thought it would be important for enrollees to be able to continue to see the providers with
7 whom they have an established relationship for some period of time around the transition, and, again, that's
8 even if the provider is out of network. And some thought that revising the effective date of exchange
9 coverage would be a way to prevent gaps in coverage.
10 Many respondents stressed the need to educate enrollees about transitions and what that meant for
11 their coverage and their care. They suggested ensuring or requiring the provision of clear and accurate
12 information on cost sharing, covered benefits, and providers. Some suggested requiring a series of notices
13 about the transition to provide information to families as opposed to, you know, just one or two notices
14 that go out. And analysis of overlap in networks across coverage programs was something that many of
15 the respondents thought would be useful.
16 Respondents were concerned about eligibility and renewal processes, particularly as they are related
17 or coordinated with the exchanges, and thought that certain streamlining strategies for enrollment would be
18 helpful, for example, 12-month continuous eligibility or express lane eligibility or just a simplification of the
19 enrollment forms. And many suggested that consumer assistance, again, would be very important, but that
20 to achieve it in the way that would be -- to achieve it in a way that would be most robust would require
21 additional funding as well as infrastructure for consumer assistance.
22 We asked stakeholders to let us know which populations of children they thought were most
23 vulnerable to gaps in care. They're listed here. I don't think there are any real surprises. Children with

1 special health care needs and immigrant families were cited quite consistently across all of the letters.

2 Pregnant women, unborn children, and children in rural areas were less often cited, but I just wanted to note

3 those for you here as well.

4 So there were many, many, many more issues and ideas offered in the letters than we could talk

5 about here today. Again, if you wanted to see any of the letters, we'd be happy to provide them. But we

6 wanted to share this with you today so that, as we move on to think about some approaches and options for

7 addressing the myriad of issues for children's coverage, we ask, Commissioners, that you just keep these

8 ideas and inputs from the stakeholders in mind.

9 If you have any questions, I'd be happy to respond.

10 COMMISSIONER ROSENBAUM: You know, something just struck me. I don't know why it

11 hasn't struck me before, but I wonder if anybody addressed it. So the family glitch, of course, is a problem

12 that affects any family whose child would be entitled to a subsidy. CHIP on average only goes up to a little

13 more than twice the federal poverty level, the average figure. So I'm wondering whether anybody raised

14 the fact that, at least on a temporary basis until the glitch is fixed, Congress should allocate more money to

15 CHIP to help any family that runs into the glitch problem to overcome the glitch problem.

16 MS. JEE: I didn't see that specifically suggested. With respect to the glitch, most people just

17 referenced the need for revising the definition of affordability, either through legislation or administrative

18 action on the part of the IRS.

19 COMMISSIONER ROSENBAUM: Right. So that obviously is the ideal solution.

20 MS. JEE: Right.

21 COMMISSIONER ROSENBAUM: But, you know, I have no way of knowing how many states

22 might, if they had an extra allocation, up their eligibility standard at least for families hitting the glitch. And

23 it really hadn't struck me until now that that's something we might want to think about.

1 CHAIR ROWLAND: Joanne, your comments and your review of the letters seemed to provide
2 remarkable consistency across all of the responses to the issues that we've been struggling with as well,
3 although these are offering some solutions that we could keep in mind and put on the table as we go
4 forward.

5 Were there any letters that raised things that surprised you or that you said, "Gee, I never thought of
6 that," or, "This is a different approach"?

7 MS. JEE: I have to be honest and say that there weren't a lot of surprises. I think I was mostly
8 struck by the consistency across the letters and the issues raised, both, you know, among the respondents
9 but with the issues, as you've said, that the Commission has been tackling.

10 CHAIR ROWLAND: Okay.

11 COMMISSIONER MARTINEZ ROGERS: It's kind of an FYI. The National Association of
12 Hispanic Nurses did get funding to sign people on to the Affordable Care Act. And we are supposed to be
13 in ten different areas of the United States, and each area is supposed to sign on a minimum of a thousand
14 people, families.

15 It has been extremely difficult to sign on people. We are, of course, dealing with Hispanics
16 because of the language issue, and even when we work with a group of a hundred people and we have eight
17 people working with a hundred people, maybe we might sign on, if we're fortunate, 40 people. People are
18 -- it's a very complex situation, and everyone that is doing -- signing on people are being trained on how to
19 sign on people. And it has become really an exhaustive endeavor. Just as an FYI.

20 CHAIR ROWLAND: You know, I think, Joanne, that this has been a helpful exercise. I don't
21 know how often we want to pursue this since we are open always to comments from stakeholders on any of
22 the work that we're doing. But I think it would be nice to reflect this effort in the introduction to our
23 chapters on CHIP, because I think the consistency is a point that would be nice to mention and that we can

1 go forward with our work there, but certainly this helps us inform the next part of our discussion, which is
2 what are some of the options for fixes for the issues we're seeing in CHIP. So I think it has been -- the
3 consistency I think is important because it's very helpful to know that there's a growing consensus around a
4 certain number of the issues. So thank you. And now I think we're calling up more CHIP people.
5 [Pause.]
6 CHAIR ROWLAND: So let us now turn to policy options, Tab 11, and we start with you, Chris.
7 Is that right?
8 **### Session 10: POLICY ISSUES AND PRELIMINARY OPTIONS FOR THE FUTURE OF**
9 **CHIP**
10 * MR. PETERSON: Yes.
11 CHAIR ROWLAND: CHIP grid. We're grinding down on CHIP.
12 MR. PETERSON: I want to begin with an overview of this session and what we are hoping for.
13 As you well know, the Commission's analytic work on CHIP during the past several months springs
14 from the Commission's recommendation last June that the Congress extend CHIP for two additional years,
15 during which time the key issues around children's coverage can be addressed.
16 That report cited some of the problems that would emerge if CHIP were not extended in the
17 scenario under current law. For the upcoming March report, the goal of the draft chapters on CHIP that
18 we presented yesterday was to bring to light much more analyses of the problems that would emerge if
19 CHIP ended, analyses by MACPAC and by others that have come out in the interim.
20 These chapters re-emphasize the need to extend CHIP in the short term and to think about what
21 needs to change if CHIP ends in the long term.
22 Now that we've laid out what is known about the potential problems, we want to begin a more
23 detailed discussion of potentially what should be done, what options are worth considering to address the

1 coverage landscape if CHIP ends at some point in the future, which options are not worth considering.
2 And to the extent that you choose that particular options are not worth continuing consideration does not
3 mean that they are not meritorious, but could illustrate, for example, that you don't want to make options at
4 the molecular level. So you have many things to think about.

5 Under Tab 11, Commissioners, you have a table that outlines a couple dozen preliminary options for
6 responding to these problems. Those options are structured consistent with the policy goals for children's
7 coverage that you articulated in the June 2014 report. The table also raises some of the tradeoffs of each
8 potential option, just to start off your discussion of issues.

9 So we have structured those options consistent with these goals, which, as you see on Slide 3, are
10 access to affordable coverage for low-income children, adequacy of coverage, smooth transitions across
11 sources of coverage, equitable treatment of states, and appropriate use of public dollars.

12 As you heard in the previous session, our work and, in fact, the options we brought have been
13 informed by input MACPAC received from stakeholders about the future of CHIP and children's coverage.
14 But there could be even more options besides those we brought. In other words, it is not meant to be an
15 exhaustive list. It's not meant to constrain you in any way. And they do not represent any kind of staff
16 recommendations. That should be obvious to the extent that they are mutually exclusive and they
17 represent a wide range of potential options.

18 On the other hand, if you want to have CHIP-related recommendations in the June report, it would
19 be very helpful to hear some of your priorities in terms of where we need to be following up for the next
20 meeting with additional analyses of pros and cons and some options.

21 So three of us are sitting up here right now -- we could easily have had Ben and Veronica up here as
22 well -- because we want to recognize how these issues all interact. And even though we've talked about the
23 issues and have draft March chapters that are necessarily siloed -- and we'll go through our presentation in

1 that model -- we don't want to limit your discussion to these kind of silos and want to bring that all together

2 now as you think about options and how they could be put together into various packages.

3 So we will do our presentation today using the structure of these policy goals and the Commission's

4 findings under each, and then we'll open it to your discussion. It is our hope that this discussion will help

5 you identify the issues most important to you and to eventually draft the broad outlines of a potential

6 package of recommendations.

7 So beginning with the first policy goal, access to affordable coverage for low-income children, as we

8 talked about yesterday, 1.1 million low-income children with separate CHIP coverage are projected to be

9 uninsured if CHIP funding runs out. And then as we look past 2019 and the expiration of the MOE,

10 which could be more children as states are able to roll back coverage of Medicaid expansion CHIP.

11 Premium contributions are generally higher for enrollees in exchange plans versus CHIP, also in

12 employer-sponsored coverage, as we talked about yesterday, but vary based on whether parents are already

13 enrolled and other factors. And then in addition to the premium contributions, there's also cost sharing so

14 that once you are enrolled, there are also costs that families have to pay out of pocket that are generally

15 higher in those other sources of coverage relative to CHIP.

16 And now I'll turn it over to Joanne.

17 * MS. JEE: The next policy goal is ensuring adequacy of coverage for low-income children.

18 Yesterday Ben described for you some of the concerns related to gaps in coverage, specifically for dental

19 care, because many exchange plans are not offering pediatric dental benefits if those benefits are available

20 through a stand-alone plan on the exchange. So families would need to actively purchase those plans if

21 they wanted to get dental coverage then for their children.

22 Ben also highlighted concerns with children's access to certain services that are less likely to be

23 covered in exchange plans. For example, we heard a little bit about audiology, and certain autism services

1 such as ABA are ones that have been shown in the research to maybe be less likely to be covered -- or are
2 less likely to be covered.
3 And, lastly, yesterday Veronica described some of the concerns with exchange plan provider
4 networks and their adequacy, and additional analysis we think is warranted on this because of the available
5 data and the concerns with the data to assess and compare networks in CHIP and the exchanges.
6 The third goal is to ensure smooth transitions across coverage sources for children, and here, you
7 know, the transitions could be for children who will churn across coverage sources -- Medicaid, CHIP, or
8 the exchange -- because of changes in their eligibility for those programs. But it also could be for children
9 who would be affected by any planned transition of their coverage from CHIP into the exchanges.
10 But regardless of why the transitions occur, children who are experiencing those transitions could
11 also then experience gaps in coverage. So we wanted to just remind you of that issue.
12 Secondly, children who move from CHIP to the exchanges could lose access to their current
13 providers. We talked a little bit about that just a moment ago, and that's if the provider networks in those
14 plans and coverage sources are different.
15 So I'll go ahead and turn it over to Rob.
16 * MR. NELB: Thanks, Joanne.
17 So another important goal that we're looking at is equitable treatment of states. The main issue
18 here deals with Medicaid expansion programs versus separate CHIP programs.
19 As you're aware, because of the maintenance of effort requirements, Medicaid expansion CHIP
20 programs must continue their programs at increased state costs, but separate CHIP programs may end their
21 programs if CHIP funding is exhausted, which would limit the state financial exposure.
22 While there's about 11 states that are predominantly Medicaid expansion states, all states have a
23 portion of their CHIP program in Medicaid expansion, so each state would be affected, but each state

1 would be affected differently.

2 In the effort to be exhaustive, we wanted to note also the unique issues for the territories which

3 receive CHIP funding through a slightly different funding mechanism.

4 And then, finally, throughout all the options, there's the goal of appropriate use of public dollars.

5 So we wanted to highlight that as MACPAC puts together recommendations, it will be important to

6 consider the federal and state fiscal impact of any of these options. And based on your feedback today and

7 as we move forward, we'll work with the Congressional Budget Office to obtain official cost estimates for

8 the policy options that are of interest to the Commission.

9 CHAIR ROWLAND: Let me ask one question.

10 MR. PETERSON: Sure.

11 CHAIR ROWLAND: If we're assuming and want to reinforce that the program needs to be

12 extended for two years, we're talking about policy options for 2016 and beyond?

13 MR. PETERSON: Well, if CHIP is extended by two years, then we're really talking about policy

14 options for 2018 and beyond.

15 CHAIR ROWLAND: So, that's my question, what year would we be asking for cost estimates,

16 then?

17 MR. PETERSON: We can do that either way. So, we can have CBO assume that there is a

18 two-year extension, or we could make it apply to 2016. And, one of the trade-offs in that ask is that,

19 typically, CBO gives us estimates in a five-year window, and so there is some concern -- a one-year window

20 and a five-year window. And, so, if you basically said, well, CHIP is extended by two years and so we

21 really don't see any impact in a five-year window until we're out in the back end of that window, there are

22 considerations. So, that's something we can think about a little more. That's a good question.

23 CHAIR ROWLAND: All right.

1 MR. PETERSON: And, then, I'll wrap it up just with the questions for discussion to turn it back
2 over to you.
3 So, as you think about these options in the table, which ones advance the Commission's vision for
4 the future of children's coverage? And, what are the relationships and trade-offs among those options?
5 And, what is the best way to weigh these sometimes competing policy goals and to minimize complexity and
6 burden?
7 So, we look forward to your discussion.
8 CHAIR ROWLAND: Anne.
9 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I just want to piggyback on something that
10 Chris said before you get into your discussion, and I think he articulated well that the list of options is
11 illustrative, not exhaustive, and, obviously, to the extent that you want to add, great. To take off, also,
12 similarly helpful.
13 I also want to point out that the list of -- the bullets that appear sort of commenting on the option
14 are similarly not exhaustive. We had at one point pros and cons and that was giving people a great deal of
15 heartburn about whether we had thoroughly articulated that. So, I think the thing that would be quite
16 helpful, if you're talking about a specific option, to let us know what you think is a particularly good idea
17 about such an -- one option, or something that gives you a great deal of concern, so that our analysis of
18 options that we will then bring to you fully reflects your concerns, which we would then be reporting as
19 pros or cons.
20 So, don't take that list as exhaustive. If there's something you want to let us know that would be a
21 pro or con, certainly, please raise that.
22 CHAIR ROWLAND: And, your intention is not -- this is not for the March report.
23 EXECUTIVE DIRECTOR SCHWARTZ: No, this is not for the March report. The -- we're

1 now looking ahead and this is, you know, the grid that you have that describes some of those, and I'm sure
2 you will reference specific options, this is not in the public domain yet, and when we come to you at the
3 subsequent meeting with policy options, that will be the first time that we're kind of sharing that discussion.
4 CHAIR ROWLAND: Chuck.
5 COMMISSIONER MILLIGAN: I was waiting for one of the old-timers to kick it off, but I'll kick
6 it off.
7 [Laughter.]
8 COMMISSIONER MILLIGAN: So, thank you for doing the work, I mean, everybody on the
9 staff. I want to -- I guess I want to start with a premise that although I was not here when the
10 recommendation was made for two years, I want to assert that I support it. So, I'm going to start with a
11 premise that what we're trying to do is to address the CHIP issues with an assumption that there's a
12 two-year extension, because I think a lot of the options you've identified, it would be difficult to implement
13 or achieve by September anyways. So --
14 CHAIR ROWLAND: And, in fact, we do want that recommendation reinforced in the March
15 chapters.
16 COMMISSIONER MILLIGAN: So, I'm going to start with that premise. My -- the way I think
17 about it, then, is what would be necessary to change to enable the simplification of a CHIP program
18 eventually phasing out and not being necessary, because I do think it leads to a lot of complications. I do
19 think it was a great program when it was enacted in the late 1990s, but I think that, right now, the
20 Affordable Care Act framework is that there's a national modified adjusted gross income standard. There's
21 a national standard for APTCs and cost sharing subsidies in exchanges. The Medicaid expansion
22 challenges aside, I think that the framework was we were moving to more of a national model for coverage
23 that didn't have gaps and didn't have quite as much variability state to state, and CHIP is an area of

1 incredible variability from state to state. So, when I think about what -- and, so, that's one sort of
2 background point I want to make.
3 A second background point I want to make is I think it's going to be important down the road to
4 identify whether the recommendation that the Commission makes is a statutory CBO recommendation
5 versus an administrative recommendation, because I think that that distinction is going to matter down the
6 road.
7 So, when I think about what would make me personally comfortable about a CHIP program being
8 able to sunset having protected the children would be to tackle it from a few directions. One is on the
9 benefit side. And, so, I think about how -- what recommendations should be made to ensure that the
10 benefits inside of QHPs, the essential health benefits, meet the needs of children.
11 So, that's a starting point, and I come at that from a view that dental should be embedded and that
12 there shouldn't be stand-alone dental plans. And, I'll tell you, having been through the launch of all of this
13 in Maryland, a lot of dental benefit companies want to have it as a stand-alone, because if they can't find a
14 dance partner on the commercial carrier side, they want to be able to still sell. But, I think, personally, it
15 needs to be embedded.
16 I think that we have to think about what the essential health benefits need in terms of the needs of
17 the low-income children we're talking about in terms of habilitation, rehabilitation, services for autism, those
18 sorts of things. And, I think, from the benefit point of view, what does that mean for cost sharing? And,
19 I think that there is -- it is, from the commercial carrier side, possible to administer different cost sharing
20 rules by age. And, so, I think that that's a way of tackling the affordability on the cost sharing side through
21 differential cost sharing.
22 So, I think for me, it's identifying that set of issues that would be part of how to make the essential
23 health benefits work.

1 The next level challenge to me is the family glitch, and I think that, personally, I won't be
2 comfortable recommending any sunset of CHIP until the family glitch is addressed, because I think that, to
3 me, that's a predicate step of being comfortable with the CHIP program.
4 And, so, I guess I'll stop there. To me, the framework is what steps need to be taken for me,
5 personally, as the Commission works through this to think about an appropriate time and set of protections
6 around which the CHIP program could safely sunset.
7 CHAIR ROWLAND: Sara.
8 COMMISSIONER ROSENBAUM: Let me just start by saying that I agree with the issues that
9 Chuck has identified. I'm a little confused -- I'm a little confused, because, in fact, a number of the issues
10 that we're talking about would not be amendments to CHIP. They would be revisions in, in fact, the
11 Affordable Care Act. And, so, they would change the way in which the tax code works on premium
12 subsidies or the Social Security Act works in terms of qualified health plan definitions.
13 So, I think, actually, the issue for me for CHIP, what amendments would be needed on the CHIP
14 side of things beyond the two-year extension, would be, in fact, retention of the incentives that states are
15 given to continue CHIP for precisely the reason that Chuck points out, that is to say, my concern all along
16 has been as long as we have the family glitch, CHIP is essential. And, starting in 2016, of course, the
17 federal contribution rate for CHIP is supposed to go way up. If it doesn't go way up, I begin to be
18 concerned about whether states will continue or be able to continue their CHIP programs. And, so, I
19 think that's actually an issue for us on the CHIP side.
20 On the side of the ledger having to do with when is it essentially appropriate to end CHIP, or to
21 merge it -- I think of it not so much as ending as consolidating a subsidy system into a uniform national
22 entitlement to subsidies -- I share the issues that Chuck mentioned, which is an elimination of the family
23 glitch, an adjustment of the premium contributions for families, whether they're buying stand-alone

1 coverage or, you know, in the event that, although it's usually not an issue where both parents have
2 coverage, but where there's an added premium cost for families, the premium exposure should be no worse
3 for families getting coverage through the marketplace than they would be paying in CHIP, so a much higher
4 level of subsidization, a correction on the cost sharing differentials between CHIP and qualified health plan
5 subsidies, and absolutely the issue that Chuck identified about the benefits.
6 There, I would not particularly do anything on the CHIP side, although I've been a firm believer in
7 raising the CHIP benefit design to the essential health benefit standard, because it's a better statutory
8 standard. But, certainly, the real issue is how does the Secretary use her administrative powers, which she
9 has under the essential health benefit statute, to define a pediatric benefit standard. I don't think -- I mean,
10 Congress obviously can do the work itself, but I think she was given all the authority she needs to not only
11 be clearer on habilitation, but on a number of different matters.
12 I did a piece of research with several colleagues looking at the wide range of benefit limitations and
13 exclusions that are in essential health benefit benchmark plans that are aimed at children, essentially denying
14 otherwise covered benefits to children because the issue is behavioral or the issue is educational.
15 So, she can override as a matter of federal policy benefit limits and exclusions that shouldn't apply to
16 children. She could be clearer on guidance on a medical necessity standard that would be more
17 appropriate for children, that would deal with growth and development as part of a medical necessity
18 analysis. And, certainly, articulating benefits, including the inclusion of a pediatric dental benefit so that
19 families always can choose a plan that includes the pediatric dental benefit without having to pay extra
20 premiums.
21 But, I think, in setting this up, we want to set it up and say, here's the recommendations we make on
22 the Affordable Care Act side and here are the things that we think are essential recommendations to go
23 along with the two-year extension of CHIP funding that we recommended earlier.

1 CHAIR ROWLAND: But, essentially, we also would be dividing that between recommendations
2 for what the Secretary can do under existing authority --
3 COMMISSIONER ROSENBAUM: Yes.
4 CHAIR ROWLAND: -- and recommendations --
5 COMMISSIONER ROSENBAUM: Totally.
6 CHAIR ROWLAND: -- about what legislative changes, because the legislative changes are really
7 assuming CHIP goes away, or how does the ACA need to be reformed to allow CHIP to be replaced.
8 And, the Secretarial changes are things that could be done now to start moving in that progress.
9 Okay. I have Gustavo, Sharon, Trish, and now Peter.
10 COMMISSIONER CRUZ: I want to ask two questions on two different subjects. One of them
11 is to Robert, and I want to thank you to bring up the issue of the territories losing the supplemental funding.
12 And, I want to ask you and the Commission if -- there is a -- there was a provision in the Affordable Care
13 Act to give a specific amount of money, and I believe it was in the range of $20 million, to territories,
14 including Puerto Rico, to sort of shore up their Medicaid system, which expanded tremendously the amount
15 of people that were covered under Medicaid. That amount of money, it's gone in 2019, and there is no talk
16 or no movement towards either continuing that funding or not. So, that would sort of almost decimate all
17 the work that had been done for the past five years. Has there been any discussion about it in the
18 Commission, something about that issue in particular?
19 MR. NELB: We can get back to you. The ACA did increase the allotments for the territories.
20 There were proposals, actually, to take away that money, but they haven't passed, and we can look at it.
21 But, as you're aware, the territories, rather than receive an entitlement, receive just a block grant --
22 COMMISSIONER CRUZ: Yes.
23 MR. NELB: -- and after they spend out that money is when CHIP comes in to sort of fill the

1 remaining gaps.

2 COMMISSIONER CRUZ: The issue there, in particular, in Puerto Rico, was that there was so

3 much money that was given for such a period of time, so there were a lot of people that were able to be

4 covered by Medicaid, and all of a sudden, it's going to be like dropping them again. So, it's a big issue that

5 I know there's a lot of discussion about it.

6 The other question, it's to you and maybe to Sara, because it's maybe a legal question. Is it feasible

7 to actually sort of prohibit stand-alone dental plans to be offered in states? Is that a feasible policy --

8 COMMISSIONER ROSENBAUM: No.

9 COMMISSIONER CRUZ: No?

10 COMMISSIONER ROSENBAUM: No. I mean, it's in the statute itself that stand-alone dental

11 plans are recognized --

12 COMMISSIONER CRUZ: Yeah.

13 COMMISSIONER ROSENBAUM: -- and importantly so. Some states, as I understand it, have

14 taken steps to ensure that families can choose a unified package because of the financial exposure problem,

15 and that's something that we might address --

16 COMMISSIONER CRUZ: But, they cannot be --

17 COMMISSIONER ROSENBAUM: You cannot -- no, no, no, no, no, no. They are a basic

18 requirement of the statute.

19 CHAIR ROWLAND: But, we could recommend that --

20 COMMISSIONER CRUZ: Okay.

21 COMMISSIONER ROSENBAUM: But, I mean, certainly for adults, where you have a benefit

22 that's not part of the qualified health plan benefit -- I mean, part of the essential health benefits, you'd

23 certainly want to make a stand-alone dental plan available. I think the problem is as that provision has

1 been applied to pediatrics. So, we could recommend that the stand-alone dental plan be legislatively
2 narrowed to adults.
3 CHAIR ROWLAND: I mean, employer-based insurance, many of the -- the coverage for dental is
4 often a totally separately administered plan.
5 COMMISSIONER CRUZ: Thanks.
6 CHAIR ROWLAND: Sharon.
7 COMMISSIONER CARTE: About nine or ten months ago when the Commission was solidifying
8 its recommendation on extending CHIP, I think I was asked on a conference call what should be the legacy
9 of CHIP, and at that time -- I've sort of been thinking about it, but, you know, I was jumping into the future
10 and thinking about things like access and quality and outcomes. But, obviously, that's still in the
11 development. It's really clear to me now that the legacy would be to have a pediatric-centered benefit that
12 would provide the platform so children can move smoothly from one form of coverage to another. I
13 think where the discussion, the points that Chuck and Sara have made that I'd like to see the Commission
14 move to make a recommendation on that the next time we meet.
15 And also to say an amen to Burt Edelstein, that would have to be included and embedded.
16 COMMISSIONER RILEY: I feel like I am going to be Debbie Downer, but I completely agree
17 with what's been said about the importance of the pediatric benefit and making sure it's evidence-based, so
18 that we can really make the case for this robust benefit.
19 But option two and option one seem a bit in conflict. We have to think about the affordability
20 issue. So as we move to a pediatric benefit in an exchange, the conversations we were having earlier, we
21 really have to think hard about affordability. It's the bigger problem of the ACA, of course, but it's also
22 the affordability to the family and dealing with the family glitch. It's the affordability to the federal
23 government, and it's the affordability to the states.

1 With CHIP, states have been making a significant contribution that will go away, and states are
2 planning for it to go away. So we really need to think about who pays for all this.
3 COMMISSIONER ROSENBAUM: The administration has proposed a more uniform definition
4 of habilitation services.
5 COMMISSIONER RILEY: Right.
6 COMMISSIONER ROSENBAUM: So, in that sense, we'd want our recommendation to
7 recognize that that issue has been addressed or is in the process, maybe, of being addressed.
8 From my perspective, because the 10 benefit classes are pretty broad -- and they're broader than the
9 statutory benefit classes in CHIP -- states can be as broad or broader, but the qualified health plan law's is
10 broader on paper.
11 I think the issue is less -- it's not new classes of benefits because the classes are pretty broad. It is
12 the fine print of coverage, and of the fine print of coverage, the big issues, I think, are when you run into
13 two kinds of things. You run into quantitative limits, and you run into qualitative exclusions.
14 The qualitative exclusions are just totally beyond the pale. To say we cover occupational, speech,
15 and physical therapy, but not for children with behavioral problems -- and yet that's in the essential health
16 benefit template in a lot of states at this point. So those clearly need to go.
17 I think that the question of quantitative limits, which is the other issue, is whether we want to
18 recommend that in the case of pediatrics, the Secretary in guidance can at least -- because this is again an
19 administrative issue. I don't think it's a statutory issue. The Secretary in guidance at least encourage
20 essentially soft limits, so that you can go through utilization review and get an extension if clinically
21 appropriate.
22 I realize that soft limits allow coverage that wouldn't otherwise be allowed, but where the extension
23 happens, because there is a finding on -- an effect on growth and evidence of children, those limits are going

1 to cluster around a very small subgroup of children.

2 So I think we could fashion language that doesn't just say children ought to have everything or we

3 should use the EPSDT benefit standard, but that certain kinds of practices that are common in adult

4 medicine from an insurance design point of view should give way to certain pediatric principles.

5 COMMISSIONER RILEY: But we still have the overlay issue of we're moving from a CHIP

6 benefit into the modified community rating world, and what do we do about the exchange structure itself,

7 and how do you subsidize that?

8 COMMISSIONER ROSENBAUM: I mean, that's where the whole question of the premium

9 affordability --

10 COMMISSIONER RILEY: Yeah.

11 COMMISSIONER ROSENBAUM: -- and the cost-sharing affordability, to the extent that the

12 benefit changes implicate the value --

13 COMMISSIONER RILEY: Exactly.

14 COMMISSIONER ROSENBAUM: -- that has to be taken into account.

15 COMMISSIONER SZILAGYI: Yeah. I'll be very brief. This is more at kind of the principles

16 level rather than the specific policy level, but I just wanted to put my support to it.

17 Particularly, Chuck and Sara were saying, the way I think about it, what are the principles that should

18 underlie the policy changes? And to me, one of the key principles is that the target population should not

19 be worse off --

20 COMMISSIONER ROSENBAUM: Right.

21 COMMISSIONER SZILAGYI: -- after two years, kind of like the physician do no harm.

22 COMMISSIONER ROSENBAUM: Right.

23 COMMISSIONER SZILAGYI: Another principle to me is that they shouldn't be worse off

1 within states, but I've always been bothered by the -- what Patricia was talking about, the incredible
2 variability. Why would a child in one state have a worse benefits -- whose responsibility is ours? It's
3 public responsibility. Why would they be worse off because they live in one state versus another state?
4 So it seems to me that we should be heading toward more of a uniform minimum requirement for these
5 children.
6 And the third point I want to make is that I think in terms of coming up with what's the best benefit
7 required components within the benefits, I think the perfect should not be the enemy of the good here.
8 The evidence is really pretty clear what children should receive, and it will be tweaked. The evidence will
9 be changed, but I just wanted to make the point that we shouldn't wait for the perfect evidence to come in.
10 I think the evidence is already really clear, and experts can guide us about what should be included in a child
11 benefit package.
12 CHAIR ROWLAND: Can I get us to clarify one thing? We are not just talking about a child
13 who previously had CHIP.
14 COMMISSIONER SZILAGYI: Absolutely.
15 CHAIR ROWLAND: We're talking about what should happen to children --
16 COMMISSIONER SZILAGYI: The future, the future target population.
17 COMMISSIONER ROSENBAUM: Primarily individual and small group market.
18 CHAIR ROWLAND: Right.
19 COMMISSIONER ROSENBAUM: I mean, that's really what we're talking about here.
20 COMMISSIONER SZILAGYI: Right.
21 CHAIR ROWLAND: I have Patty and then Donna.
22 COMMISSIONER GABOW: Actually, that was the point I was going to say we should be very
23 clear. One of the things we've talked about here is that Medicaid and CHIP are really part of the whole

1 health care system for America, and while we, I think -- well, I don't know that we all agree, but I agree with

2 sort of what's been said.

3 The exchange was established to really absorb CHIP, and we have to make sure that kids are not

4 worse off. I agree with that.

5 But we also should think about, I think as we come to grips with what is the essential benefit

6 package for children, that it applies to Medicaid, that it applies to commercial insurance, and that we are

7 talking about what do we need to have healthy children for America. To the extent we can get

8 concordance about that benefit package across all, then the transitions that will inevitably happen with this

9 population become smoother and less difficult for the child in the family, and I think for the country. All

10 this juggling is, administratively, a mess.

11 So I think if we think about it broadly, as you were saying, I think that's really important.

12 COMMISSIONER CHECKETT: I wanted to address a couple of comments. As I recall our

13 discussion that was, I think, very protracted and we took very seriously -- it was really the first kind of big

14 recommendation that came out of the Commission about the two-year extension -- one of my recollections

15 about why we settled on two years is that zero was clearly not acceptable.

16 But we didn't want to go with four years because it was almost like just pushing off the issue, and so

17 we really settled on two years, as to say that will drive a discussion that needs to be had, and we talked about

18 the family glitch. We talked about all these issues that have come up.

19 So I think reflecting on the deliberation and how long we spend on that and a lot of research that

20 the staff had conducted to look at the cost of different decisions, my concern would be we may not need to

21 be perfect, but I don't think we're ready to have a vote, for instance, that I heard Sharon saying for the next

22 Commission meeting at the end of February to make a vote on whether or not we should go forward with a

23 recommendation on a child package or what a set of benefits should have.

1 I think it's a great, a really great discussion that we're having. I see this as being really the next step
2 to a discussion we've had about the CHIP extension in terms of funding, but I'd look for February being -- I
3 mean, I personally would like to see, well, what could the benefit packages be and what do the various
4 professional associations recommend, and what will those costs be.
5 So I love the discussion, but I want us to undertake it with all the deliberation and analysis and data
6 that we need to. We may not be perfect, but I don't think we're ready, so thank you.
7 CHAIR ROWLAND: I also think, in that sense, the family glitch is much more than CHIP issue.
8 It's really an Affordable Care Act writ broadly issue.
9 It would be helpful to just look at the implications for CHIP if the family glitch were fixed. How
10 much of what we're concerned about is driven by the family glitch, and then what other options would we
11 want to consider?
12 COMMISSIONER CARTE: Actually, I just wanted to say that I think I was offering that we
13 should recommend broadly, as a matter of principle, as Peter was saying, a pediatric-centered benefit as an
14 order not to go to the granular level of what it needs to be, perhaps.
15 COMMISSIONER ROSENBAUM: The family glitch only fixes the premium problem.
16 COMMISSIONER CARTE: Right.
17 COMMISSIONER ROSENBAUM: We've still got -- and we should make that very clear that
18 we've still got coverage-related questions, the quality of the coverage itself. Both the scope and depth and
19 the cost-sharing questions are very important, and that's going to take, I think, considerable developmental
20 time.
21 CHAIR ROWLAND: But my thought is if we could, at least in the premium issue, look at how
22 much of it is caused by the family glitch and how much of it is caused by the fact that even if you fix the
23 family glitch, it's too low. So I think that sets the policy out in a different way than just to keep looking at

1 it as a combined effect.

2 Chuck.

3 COMMISSIONER MILLIGAN: I want to pick up on this, and also, I like Peter's framework

4 about some principles.

5 When CHIP was enacted, just a little context, you could cover children under CHIP up to 200

6 percent of poverty, unless you had a Medicaid program that covered kids up to a higher percent of poverty

7 already, in which case you had to maintain Medicaid effort at that level. You couldn't just swap out CHIP

8 funding for Medicaid, and you could go up 50 points from wherever you were. And so that led to and has

9 continued to lead to a tremendous amount of variability about eligibility for CHIP, and you all sort of

10 alluded to that.

11 But there are states that cover CHIP below 200 percent of poverty at their max, and there are states

12 that go up to 300, 400 percent of poverty because of starting points and allotments.

13 I want to come back to one of Diane's points, which is I think that framing it about children, in the

14 context of a lot of kids in CHIP and what becomes of them, but that means children, it's the benefits in

15 QHPs as an implication in this, because there are some states where children at 190 percent of poverty are

16 not in CHIP and some states where they are. If we think about this as a CHIP-specific issue, we're going

17 to be replicating the variability challenges, which doesn't seem equitable to me.

18 So it's really -- my starting point is what would I personally feel comfortable in terms of a CHIP

19 sunset as I mentioned, because if there's seamlessness, if there's more uniformity, if it's more of a national

20 model, that also has implications of what's QHP.

21 I just think that contextualizing the tremendous variability about CHIP eligibility levels and if CHIP

22 were to go away, that has, socioeconomically, very different implications based on what state somebody

23 happens to live in. So, to me, it then becomes, to Donna's points, what should the QHP look like,

1 subsidies look like, essential health benefits look like, family glitch, in a way that addresses this more a
2 national, systemic, thoughtful, principled way.
3 The last point I want to make -- and I do want to emphasize something I said earlier -- I think it will
4 be really helpful to understand what can be fixed administratively versus what requires statutory change.
5 Sara mentioned a few that are very administrative about the Secretary's authority, about essential health
6 benefits, about dental being part of offerings and so on. I think some of the family glitch and identifying
7 what can and can't be changed at Treasury and IRS, that will drive a lot of the congressional implications of
8 what eventually we do. It will drive CBO implications eventually of what we do. It will drive who bears
9 the burden of cost, state and federal government, about what we do.
10 I think being very clear about the mechanism by which the recommendations eventually need to be
11 advanced will be helpful in the decision-making process. So I'll stop there.
12 COMMISSIONER SZILAGYI: A 30-second addition to what Chuck was saying, in my own mind
13 -- and this is because I'm new on the Commission -- this concept of thinking about why should a child be
14 different if she is in one state versus another kind of moves me from being in a defensive posture of how do
15 we do no harm or protect children to how can we actually make a better program than CHIP in the future
16 for both the kids who are currently in CHIP and for kids who will be eligible in the future. It kind of puts
17 me in a more positive thinking frame.
18 MR. PETERSON: Can I then try to put together some of the pieces that have been talked about
19 here, just to give an example, on comments that various Commissioners have given?
20 You expressed willingness to address the family glitch. Also, though, keep in mind that among the
21 1.1 million children who we project would be uninsured post-CHIP, 40 percent of them are eligible for
22 exchange subsidies. So just fixing the family glitch by which you mean let kids who are eligible for ESI
23 also be eligible for subsidized exchange coverage is not necessarily going to fix the uninsurance problem

1 totally. Another step is necessary with respect to the affordability, which you have mentioned.

2 Then you combine that with a desire to improve the benefits, to embed dental, but then that also

3 comes at increased cost, and in the context of, well, children will receive tax credits for that, the federal

4 government can pay for that, so that may be true for some. Is it true for all kids? So does the benefit,

5 increased benefit that you want, are you envisioning that being for all kids in QHPs because then that has

6 the cost implications that you mentioned?

7 So not necessarily for you to comment on, but just to realize that as we start to try to put these

8 pieces together, this is how they begin to interact.

9 COMMISSIONER ROSENBAUM: I am barely holding it together here.

10 I was up all night writing. Go back to your 1.1 million. If you got rid of the family glitch, why is

11 it that we still have so many children who would be ineligible for the subsidies?

12 MR. PETERSON: A different thing. So if you said -- so put aside the 1.1 million. If you said

13 let's fix the family glitch and let's let more kids be eligible for subsidized exchange coverage, many of those

14 families are not now enrolled in subsidized exchange coverage. They are going to have to pay premiums

15 out of pocket. So if they are uninsured now, they will still be uninsured if you fix the family glitch.

16 COMMISSIONER ROSENBAUM: So there's no bar or nothing. There is no reason why like

17 the family glitch, but there is an affordability bar.

18 MR. PETERSON: Exactly.

19 COMMISSIONER ROSENBAUM: Got it. Okay.

20 MR. PETERSON: And that's what isn't currently in the situation now with respect to

21 affordability.

22 MR. NELB: It was Chris who mentioned that we presented yesterday that distinction whether the

23 child's parents are enrolled in exchange coverage or not affects sort of the marginal cost for adding the

1 child, because the tax credit is based on the whole family and doesn't make a distinction based on number of

2 people enrolled.

3 COMMISSIONER ROSENBAUM: And that was your comment, Diane, separating out the

4 tuition.

5 CHAIR ROWLAND: The tuition.

6 The other issue that I think we can't lose sight of is that we also have CHIP kids who are in

7 Medicaid, and so I think in looking at our options, we also have to figure out what to do on the Medicaid

8 side. We can't just always be looking at going to the exchange.

9 COMMISSIONER ROSENBAUM: After 2019, those children may get migrated, so we've got to

10 think about that.

11 COMMISSIONER MILLIGAN: Yeah. And to that point, I think, Chris, you are raising a good

12 aspect of this on affordability and who pays.

13 I think one of the pieces I mentioned in my first comments was about the cost sharing, below 250

14 percent of poverty of cost-sharing protections, and I think those have implications here too.

15 But I want to come back to what Diane just said. So if you look at what are the inputs and the

16 takes financially and whose budget it is, for the Medicaid expansion states, there is this implication of regular

17 Medicaid match if CHIP goes away, and then in 2019 addressing that congressionally, one way or the other.

18 So I think that part of my framing of what I think about CHIP going away is also, even in those

19 Medicaid expansion states, if there are ways of improving the QHP world with subsidies and benefits and

20 cost sharing, there are federal savings that could accrue from Medicaid match for CHIP expansion

21 eventually going away and the federal funding of CHIP, however it's budgeted, going away.

22 For the states, one of the issues of state budgeting that we haven't talked about is there's been

23 tremendous take-up by the groups who are eligible, enrolled but previously eligible at the regular match rate,

1 a huge portion of who's come in through the ACA expansion, which isn't 100 percent federally matched.

2 So I just think that putting these pieces together about framing the financial implications of the

3 recommendations, there are some potential new costs we're talking about related to the subsidies and cost

4 sharing, and maybe more of the premium cost, because we're talking about a robust pediatric benefit, it

5 drives up APTCs, but at the same time, there might be federal savings related to the federal match rates that

6 are embedded in some of these other workaround programs.

7 I just think we need to not talk about it without thinking of all of the interlocking pieces.

8 CHAIR ROWLAND: You know, I tend to think in tables sometimes. So I think we also need to

9 have, as kind of just a background piece, the states, what their income eligibility levels are, whether they're in

10 Medicaid, what levels are in Medicaid, what levels are outside, just so that we have some framework of the

11 number of kids that we're talking about, which states we're talking about, and which income levels.

12 Because as you said, almost every state has some kids in Medicaid; at least all the ones up to 138 are

13 someday going to be in Medicaid. And I think we need to look, as Chuck said, at the variability of what

14 the CHIP income eligibility levels are.

15 Now, as I recall, the majority of kids covered by CHIP are at 200 percent or below.

16 EXECUTIVE DIRCTOR SCHWARTZ: 90 percent.

17 CHAIR ROWLAND: 90 percent. So, you know, as we've raised it, is there something -- if we

18 were doing something that's more income related, is there something different about that 10 percent that are

19 above that we would treat differently?

20 MR. PETERSON: And just note, though, that that 90 percent is based on pre-ACA numbers, so

21 MAGI and other things that are happening are going to change that.

22 CHAIR ROWLAND: Okay. Other comments, other suggestions for work?

23 COMMISSIONER RILEY: I just think yesterday, when you were chatting, I think we really

1 should call Chris "Chip."

2 [Laughter.]

3 CHAIR ROWLAND: Chip Peterson.

4 COMMISSIONER CARTE: I just wanted to, perhaps for our newer Commissioners, when we

5 talk about broader principles, those wouldn't necessarily need to come in the form of a recommendation,

6 but could possibly even be in a letter to the Secretary if we wanted to address those sooner rather than later.

7 CHAIR ROWLAND: Okay, great.

8 Any other comments, questions?

9 [No response.]

10 CHAIR ROWLAND: Chip Peterson, good luck.

11 [Laughter.]

12 CHAIR ROWLAND: Yes, to our CHIP-pers, thank you very much.

13 Now we'll turn to a public comment session. If there are comments from the public, we would

14 love to hear them. Again, we always like to also get any comments you wish to offer to us in writing so

15 that we can distribute those to the Commission members and be sure we're hearing from you.

16 ### **PUBLIC COMMENT**

17 * [No response.]

18 CHAIR ROWLAND: Okay. Seeing no one at the mic, we will thank those who attended this

19 session with us, those who contributed to the session, especially the staff for all the work they've put out for

20 us to be able to have the deliberations we've had the last day and a half.

21 Thank you to all my Commission members and especially thank you to the new Commission

22 members who have joined us in full force, and we look forward to seeing everyone again next month.

23 Thank you.

24 * [Whereupon, at 11:23 a.m., the meeting was adjourned.]