MACPAC

Medicaid and CHIP Payment and Access Commission

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PUBLIC MEETING

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

Thursday, December 11, 2014
9:38 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
RICHARD CHAMBERS
DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
BURTON L. EDELSTEIN, DDS, MPH
PATRICIA GABOW, MD
DENISE HENNING, CNM, MSN
MARK HOYT, FSA, MAAA
NORMA MARTINEZ ROGERS, PhD, RN, FAAN
JUDITH MOORE
TRISH RILEY, MS
SARA ROSENBAUM, JD
STEVEN WALDREN, MD, MS

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S [9:38 a.m.]

CHAIR ROWLAND: Welcome to this session of the Medicaid and CHIP Payment and Access Commission, our December meeting. This morning, we will be really looking in depth and continuing our discussion of the CHIP program and its future and the issues in the transition.

But, I wanted to begin this meeting today by thanking and commending the Commissioners who have served us since our launch, our founding Commissioners, whose appointments will be ending at the end of December: Richard Chambers, Burt Edelstein, Denise Henning, Judy Moore, and Robin Smith, who has been our consumer rep, who is not with us today, and our Vice Chair, David Sundwall.

We have struggled in the last five years to figure out what a MACPAC Commission should be doing and can do. We have come together to really help provide a framework for how this Commission can continue to look for ways to improve and strengthen Medicaid and CHIP in their role of taking care of some of our nation's poorest and most vulnerable residents.

And, I would like to really start this meeting by thanking our Commissioners and asking them if they would like to share any of their parting views with us, and I turn first to my Vice Chair David Sundwall.

VICE CHAIR SUNDWALL: Well, thank you, Diane, and good morning to everybody. This is difficult to say at our last meeting, because I think any of us who have been on the Commission are going to miss this experience.

First of all, I really do want to commend Diane Rowland. She has done a remarkable job as the Chair, helping us establish ourselves and credibility, which I think is essential.

My personal perspective is -- which makes the work of this so important -- is, number one, I live in a state that has been wrestling with this expansion thing now for, gosh, five years? Anyhow, the law passed in 2010. Our opportunity for expansion has been studied to death, but we are in the process of getting a waiver from HHS and possibly getting approval by the legislature. But, it has been so front and center in our state and so much public discourse that while I am glad to see Medicaid in the news, I am frustrated as can be, because my other perspective, aside from a policy/public health person, is that of a clinician. I see patients in clinic every week, two days a week, where I see people who are on Medicaid or wish they were because they are uncovered, and so I see the need firsthand and how important it is for people to have coverage, and Medicaid, with all its flaws, is certainly important to access to health care.

The other thing I wanted to just mention, and it's been fun for me because this has been a learning experience. I feel like I go to school every time I come to these meetings. Most people here know a whole lot more about Medicaid and the details than I do, so it's been a great learning experience.

The last point I want to make -- I don't want to take too much time, but it's terribly important that this Commission has strived to be nonpartisan. I'm the only clearly identified outspoken Republican --

[Laughter.]

VICE CHAIR SUNDWALL: -- and I make my views known and the committee, while they disagree with me sometimes, has been respectful, and I think we've tried very hard to be sensitive to conservative points of view, liberal points of view, and find that nonpartisan perspective, and that's going to be all the more important as we go into this new Congress, and I'm certain the Commission can somehow

navigate those waters. And, if I can help in any way, I'll be glad to do that.

Also, one more point. Thank you for paying attention to population health. We had a section in the June report last year, and I would charge the committee to continue. I will haunt you if you don't keep talking about public health, population health, how Medicaid can be a tool to improve everyone's health, not just those on Medicaid. So, don't forget that important aspect.

And, lastly, thank you to the staff. You are outstanding. I mean, we all benefit. We bask in your expertise. So, we take credit for all the hard work you do, and I just want you to know that all of us appreciate what you do. So, thank you.

COMMISSIONER CHAMBERS: Okay. Thank you, Diane. Thank you, David. We very much have appreciated -- at least I have, I will speak for myself -- appreciated your opinions and the perspective you have brought to this Commission.

But, it's really been a privilege and honor to serve for the last five years on this Commission. It was a big surprise to be appointed in the first place, with all of the folks around the country who have lots to contribute to this Commission. But, it's been, as David said, an education process. It is the, you know, incredible knowledge and experience and commitment of the 17 Commissioners has been overwhelming to experience and have the privilege on a, almost a monthly basis of our meetings over the last five years, to learn and share and to work on things that we all are here for the single purpose of, the populations that we've committed our careers to over the years.

I think I would be remiss as not to thank the staff, incredible group of folks. We've had some who have been here throughout the five years, others who have been in the past, but overwhelmingly,

a talented group of people that we certainly couldn't do our work without you.

And, to Diane and to David for their leadership. It was great. And, Anne, your leadership as Executive Director. We can't forget Lu Zawistowich, the original Executive Director, who helped us get formed.

It has been, again, a great experience. There's a lot ahead. I personally have been very supportive of term limits on boards and commissions because I think it's good always to get new perspectives. And, with two-thirds of the membership staying here, I'm sure there will be great continuity for all the important issues that are ahead.

For me, personally, I look forward to continuing to focus on my broken record issues of managed care and duals at the much more local level. Unfortunately, Robin is not with us, Robin Smith not with us today, but I remember she told me -- the first time I met her, she says, "I have nothing against managed care. I just would like to see good managed care." And, so, I am going to continue that commitment, as to make sure that, at least at a local level, is to strive to make good managed care happen.

So, thank you all for the privilege of being part of this Commission.

COMMISSIONER HENNING: I also join my colleagues in thanking Anne and David and Diane and the staff for all your good work that you've done over the years, and, of course, Lu. Who can forget Lu.

I hope that the person that replaces me brings a consumer perspective to maternity care and keeps that at the forefront, because in the final analysis, all of the work that we do here should be for the good of the consumer. And, if we don't take care of pregnant women and their unborn children, then

we've really failed as a Commission.

I think maternity care is important. Of course, I have a bias. I think it's the most important issue out there in health care.

COMMISSIONER EDELSTEIN: Second to dental.

COMMISSIONER HENNING: Second to -- no, sorry --

[Laughter.]

COMMISSIONER HENNING: -- it's more important than dental, but it's close.

[Laughter.]

COMMISSIONER HENNING: I hope, also, that I've brought a little bit of a focus on the fact that there are other providers out there besides doctors, that there are nurse midwives that deliver babies, that there are nurse practitioners, that there are PAs, that there are other people out there providing health care these days and that they are a big part of the access problem that we have in this country. And, as we expand access to insurance, we also have to have access when it comes to providers in order to provide the services that are going to be important for the people that now have insurance. So, I'm hoping that that got across.

And, I also hope that we continue to focus, or bring new focus to the quality of the services that we provide, so that we're just not giving visits, but we're actually giving services that increase outcomes and increase the quality of care that people get. So, that's my hope for the future.

COMMISSIONER EDELSTEIN: I was reflecting on our first coming together five years ago and becoming a functional group, which took us some time because it was an entirely new endeavor and

one that we had to figure out.

One of the things that I appreciated most as I got to know each of the Commissioners was how much I didn't know about aspects of Medicaid and how much they didn't know about aspects of other -- other aspects of Medicaid. It came to be a real learning experience for each of us as we grappled with this elephant and got to understand how multi-faceted and how dynamic a program it is.

I appreciated, in particular, the work that I think Trish pushed us to consider, which was how Medicaid fits in our overall health care system and the role of Medicaid that we all took up, Medicaid and CHIP, especially CHIP now, the role of Medicaid and CHIP in our overall health care system.

I think I did bring a peculiar perspective to the group, not because of my oral health focus but because of the only person who is, at least publicly acknowledged, having been a Medicaid recipient. Having been a Medicaid recipient now nearly 50 years ago, I have very sharp recollections of the discrimination, the bias, the inappropriate management of some acute health care experiences that my family confronted and echo Denise's call for always remembering the consumer.

I have strived over our time together to encourage all to recognize that there is an absurdity, a physiologic inappropriate absurdity in Medicaid statute that allows the mouth to be segregated from the rest of the body.

[Laughter.]

COMMISSIONER EDELSTEIN: I remain disappointed that the Commission has not been able to focus more attention on this, because it's such a discrete, small issue that is readily fixable, so I look forward to the successor who assumes my slot representing oral health interests in being more effective

in continuing that endeavor.

On the other hand, there has been a chorus around the table of recognition about the importance of oral health, and I feel a little bit like Norm on "Cheers." When he walks in, everybody says, "Hey, Norm." Every time the oral health issue is recognized, each of you now is my surrogate. I hear, "channeling Burt" as a common refrain.

Most of all, I appreciate the quality of the leadership and the staff and the terrific quality of the members and have thoroughly enjoyed getting to know the Commissioners and look forward to not leaving you alone as we continue to pursue our shared interests. So, thank you.

COMMISSIONER MOORE: I think that I was appointed to this Commission partially to represent the history of the program. I go back to the 1960s as a federal employee involved in the Medicaid program, so I'm kind of the old historian here. I'm hoping that I have been able to put in context some of the things that we've talked about and the way the program has evolved and changed over the years.

And, in that light, I was briefly out of the Medicaid experience as a federal employee, and part of the original ProPAC, which became MedPAC, as a staff member, so I had been looking forward to a day when there was a Medicaid Commission for over 20 years, before MACPAC was finally enacted into the statute. So, in that sense, it was a real dream of mine from, really, the 1980s on, and to see this Commission formed and then to become a part of it was just an enormous pleasure for me.

In the initial years, I think we did a great job of setting the stage for this Commission to provide more and better information, analysis, communication about this program, which is so

misunderstood, has been so misunderstood and so little understood, even in Washington, over the years. I think that this is enormously helped by the leadership we've had here through Diane and David, through Lu and Anne and this fabulous staff that provides us with such wonderful briefing materials and reports that have been put out since our second year of existence, which was pretty impressive, as well.

I hope that all of this better understanding that we are facilitating, I hope, will lead to better decision making around Medicaid, both at the federal and the state level, better -- and a better program for the 60-plus million people who we serve through this program who should always be our first and most important focus, be they pregnant women or old or disabled folks in their own homes or in nursing homes, wherever they may be. That should always be our first focus, and I hope that the Commission continues to approach this program in that way. Thanks. It's been a great pleasure.

CHAIR ROWLAND: And, thank you all. I mean, the founding of this group and figuring out how to put together an agenda and how to work on developing these reports with the guidance that we got from the federal statute and the help that we got in shaping that agenda from all of you has been much appreciated and, I think, it sets a high standard for those who will join us.

And, with that, we should also continue our work today. We're not done. We're, in fact, in the middle of our report cycle. So, I'd like to turn to our CHIP presentation, and Joanne, if you want to come up and review for us our analytic plan, what the pieces are that we're putting together, and also tell us what some of the Governors have advised the Congress that they would like to see happen to the CHIP program.

THE FUTURE OF CHIP

SESSION 1A

MACPAC ANALYSIS PLAN AND REVIEW OF GOVERNORS' LETTERS

* MS. JEE: Great. Thank you. Good morning, Commissioners. We wanted to start today's discussion of CHIP in the same way we've started previous meetings. I'll first give you a brief overview on the currents status of efforts to extend CHIP funding. Then I'll update you briefly on the status of our analytic work so far, and we're going to run through the Analysis Plan, as we've done before. And then we'll end this session with some highlights from the letters from governors in response to the congressional letter on the future of CHIP.

The current status of CHIP is really much the same as what we reported in October, and that is that there has been no new congressional activity related to extending the funding. The Health Subcommittee of the House Energy and Commerce Committee did hold a hearing last week, but as far as we know, it does not appear that there will be any action during the remainder of the lame duck session.

Chris mentioned last time that the states are really beginning to formulate their state fiscal year 2016 budgets, which in most states begins on July 1, 2015. That, of course, hasn't changed, but I just wanted to remind the Commission of this. This is an issue that the governors really pointed out in their letters in response to the Hill letter.

So turning to our Analysis Plan, which you'll recall included several topics that we intend to cover during this meeting cycle, I'm just going to run through the list and let you know, you know, where we are on these topics.

During the October meeting, we discussed how CHIP and exchange benefits and cost sharing compare based largely on research that occurred in the states with separate CHIP programs. We also began the discussion on consumer protections and whether they are adequate for children who will move between different coverage sources, and that really was just the beginning of that conversation.

We've also touched on the impact of future CHIP funding on state and federal budgets. We're working on updating the analysis on where states are with their CHIP spending and when they might expect to exhaust their allotments. So you'll be hearing more on that as well.

So today Chris is going to share some results with you from a different analysis -- and these are just some preliminary findings -- that updates and refines what coverage sources children who currently are enrolled in CHIP will be eligible for and might ultimately enroll in.

Then Rob and I will address affordability of coverage for children who have transitioned from CHIP to QHP coverage in the exchanges. We're going to outline some potential options for addressing some of the affordability issues.

And then Veronica will update you on some of the themes that emerged from a recent roundtable that MACPAC hosted on pediatric network adequacy.

So, Commissioners, as you look at this list, you'll see that each item has a check mark by them. I will just emphasize that while we've touched on each of these issues, because the issues each are so complex and your consideration of each of them is ongoing, we do plan to return to you with some additional research and analyses on these topics.

So now turning to the letter from the Congress, this summer the House Energy and

Commerce Committee and Senate Finance Committee sent a joint letter to the governors asking for their points of view on the future of CHIP funding. The letter went to the 50 states and asked various questions -- about six or so -- all related to CHIP, and we were able to review 40 of those letters.

This slide lists the key takeaways from the governors' responses to those letters. Most states explicitly articulated their support for ongoing funding for the CHIP program. Most states supported a four-year funding renewal, but there was a range offered in those letters with some states suggesting a two-year renewal and some states suggesting an indefinite funding renewal.

There were three states that explicitly stated their belief that the exchanges could adequately meet the needs of children. One of those states, though, did support a two-year funding reauthorization during which time needed policy changes could occur, which, as you know, is consistent with the recommendation that the Commission made previously.

The consensus among the governors was that the CHIP coverage is more generous and more affordable than exchange coverage. That is perhaps not a surprise, and we'll revisit this in just a minute.

The governors also overwhelmingly stressed the need for an expedited decision on CHIP funding given their state budget cycles. Many of the governors said that the deliberations on their state budgets would occur soon, probably no later than March 2015, which is pretty -- right around the corner.

And the majority of states indicated that the current structure for redistributing the unspent CHIP allotments was working well for them. A couple of states suggested that some additional flexibility in how some of that money could be used would be helpful, but, again, overwhelmingly the answer was yes,

the structure is working.

So governors were asked to share what their concerns would be if CHIP funding were not renewed. Many governors noted the successes of their CHIP programs in reducing the uninsurance rates and indicated that they were concerned that, absent CHIP, those gains could be reversed and the uninsurance rates among children would increase.

Some governors shared concerns with the higher premiums and cost sharing in QHPs and what that would mean for children and their families.

Governors also noted that there are some differences in covered benefits between CHIP and the QHPs. Some of the governors reminded the Congress that in their CHIP programs children were receiving the EPSDT, or the Early and Periodic Screening, Diagnostic, and Treatment benefit, which is really more expansive than any benefit provided in private insurance.

They particularly highlighted as areas of difference behavioral health care and dental health care, noting that the CHIP coverage is more generous than private coverage where that private coverage is available.

And, lastly, the governors noted that in states with Medicaid/CHIP expansions, coverage for those children would continue even if CHIP funding were not extended at the lower Medicaid matching rate and noted that that difference in matching rate could create some gaps in their state budgets.

The congressional letter asked the governors to identify policies or policy changes that were needed that could help improve -- or that could help reduce the numbers of children who were eligible for coverage but not enrolled. They identified several strategies, and the ones listed on this slide here are the

ones that were the most common among the governors.

Consistent with their concerns around affordability, governors thought that addressing the family glitch would be important to do. As a reminder, the family glitch is the circumstance in which families are not eligible for subsidies on the exchange because they are determined to have access to affordable employer-sponsored coverage. However, the affordability standard is based on the coverage of the employee-only coverage rather than the family's coverage.

Governors suggested that supporting ongoing state efforts to simplify and streamline enrollment such as the CHIPRA bonus fund would be helpful. The CHIPRA bonus funds provided bonus payments to states that met certain criteria such as implementing certain strategies to simplify enrollment and improve retention. That bonus fund expired at the end of fiscal year 2013.

States also suggested additional support for outreach funding and thought that providing CHIP premium subsidies for the purchase of QHP coverage or employer-sponsored insurance would help reduce those rates of children who are eligible but uninsured.

So, overall, the letters to the governors were very supportive of ongoing funding for CHIP. They were concerned about differences between CHIP and QHPs, probably more so on the cost-sharing side than the benefit side. And while they credited their CHIP programs with drastically reducing uninsurance rates in their states, they did acknowledge that there was more work to be done in their states with reducing the rates of uninsured children.

Well, that is the end of my presentation. Sorry about the technology glitch.

[Laughter.]

MS. JEE: I'd be happy to answer any questions.

VICE CHAIR SUNDWALL: Thank you. I'm glad to know the governors are supportive in general, although I'm sure there's a spectrum of things they would do with these strategies.

I have a question on the very last bullet you had on which you said CHIP premium subsidies to purchase qualified health plan coverage. Could you explain that? Is this CHIP premium subsidies available on exchanges that they would use to buy private insurance?

MS. JEE: So this is not currently a strategy available. I think the question that was posed to the governors was, you know, what are some ways that we could think about to improve, you know, coverage among children who are currently eligible but uninsured? And the responses really ran the gamut. But the suggestion here was to, you know, think about providing -- using CHIP to subsidize potentially some insurance for these children who might move to the exchange on the QHP. So it was a suggestion.

COMMISSIONER ROSENBAUM: Isn't it the parallel to Medicaid premium assistance --

MS. JEE: Yes, it would be -- exactly.

COMMISSIONER ROSENBAUM: Essentially, instead of having a separate CHIP product market, you would take your CHIP subsidy --

VICE CHAIR SUNDWALL: Right.

COMMISSIONER ROSENBAUM: -- and buy a qualified health plan.

VICE CHAIR SUNDWALL: Okay. Interesting. So it's just premium assistance through the CHIP program. All right.

CHAIR ROWLAND: [off microphone] the problem of the cost sharing and benefit.

COMMISSIONER HENNING: Right, and then also, you know, the coverage differences would still be there as far as, you know, potentially not having dental coverage unless you bought a separate dental policy. That still would remain.

VICE CHAIR SUNDWALL: Are you channeling Burt?

COMMISSIONER HENNING: Yes, I am.

[Laughter.]

COMMISSIONER ROSENBAUM: You'd have all the same problems that we flagged around qualified health plans generally, so the model could be combined with improvements to qualified health plans.

COMMISSIONER CHECKETT: Or with an additional supplemental policy that would make up the difference between the QHP and the CHIP benefit.

CHAIR ROWLAND: It's actually kind of using CHIP to get around the family glitch.

COMMISSIONER ROSENBAUM: What's not clear to me, though, is why it would be in a state's interest to do that as opposed to fixing the family glitch, since the state would have to pay a portion of the premium subsidy. If we fixed the family glitch and fixed the qualified health plans, then that would seem to be a better result for the states. So I'm a little confused by that.

CHAIR ROWLAND: I guess a question is: Was this proposed by many governors? One governor?

MS. JEE: I won't say many, but probably more than one. You know, as I said, there were

lots and lots of strategies that were proposed, and these were sort of the top. I would say it was probably a small handful, less than ten.

CHAIR ROWLAND: But it's helpful to know what was being proposed, so as we look at options and ways to structure it, we know what other thinking is going on. So thank you, Joanne.

And we'll have Chris come now and brief us on some of the estimates of eligibility from the separate CHIP programs. Remember, this is the work we're doing to try and get a handle on how children would be affected depending on what happens with CHIP funding.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah, and just for Commissioners, we flipped the order that is in your book, so we're not at Tab 2C, and then we'll come back to Tab 2B. In retrospect, this seemed like a better flow.

CHAIR ROWLAND: 2C, Updated Estimates of Eligibility for Separate CHIP Children in a Post-CHIP Landscape.

SESSION 1C

UPDATED ESTIMATES OF ELIGIBILITY FOR SEPARATE CHIP CHILDREN IN A POST-CHIP LANDSCAPE

* MR. PETERSON: Thank you, Diane.

As you know, MACPAC is supporting enhancements to the Urban Institute's microsimulation model so we can get updated projections, first, of how many children would be uninsured if CHIP ends; and, second, to help assess the impact of various options to prevent such uninsurance in a post-CHIP landscape.

The Urban Institute, in collaboration with the Agency for Healthcare Research and Quality, or AHRQ, has been working hard to build in these enhancements. Today we have a couple preliminary estimates to report from the model. We are not yet able to project how many children would be uninsured in a post-CHIP landscape. We hope that will be available in our January meeting.

The preliminary estimates I am presenting today show what kind of coverage separate CHIP children would be eligible for in a post-CHIP landscape, not yet what premiums they would face and what they would enroll in. This is the same estimate essentially that we provided in our June report, and as you will see, the results from Urban's model are nearly identical, which is reassuring as the work progresses.

As we build toward the results in the January meeting, we want to take time here to give you an overview of the Urban Institute's microsimulation model, to provide the preliminary results from the model, and compare those to those that we previously published and then to discuss the next round we expect to see in our January meeting.

So why use microsimulation modeling? One of the primary reasons is because not all families are average. We often illustrate the effect of various cost-sharing and eligibility requirements on the average family. This is what the average family would face; this is the average premium or median premium. But we know that, in fact, out-of-pocket premiums vary for a variety of factors. When we look at job-based premiums, those premiums vary across states, industries, who owns the firm, the age of the firm, and a bunch of factors, and then how much do the employers actually contribute toward that coverage versus the employees. That all varies as well by a variety of factors. And as will be talked about in a minute by Joanne and Rob, subsidized exchange coverage and what people pay out-of-pocket varies by

their income, family size, the cost of the second lowest cost silver plan in the state's rating area and other factors.

And then, once people have selected a plan, enrolled in a plan, what they pay out-of-pocket for their cost sharing is going to vary, and so all families are not average in that regard. So that's one of the primary reasons to use microsimulation modeling because it allows us to simulate the impact on all families across the spectrum of experiences.

Such models are generally based on nationally representative surveys of individuals and families, and then added to the model are the national and state eligibility policies and the costs that people would face in Medicaid, in CHIP, and now in the landscape as revised by the ACA, we have QHPs, but also job-based coverage.

So then, based on all of this information, each family is assessed in order to project what are they eligible for, how much is that coverage going to cost, would they enroll or would they be uninsured, and then if different proposals were implemented, what would the impact be in terms of changing their coverage under various scenarios.

On the Urban Institute model in particular, it is known as the ACS-HIPSM, which stands for the American Community Survey-Health Insurance Policy Simulation Model -- that is their latest version -- and it relies primarily on the Census Bureau's American Community Survey, or the ACS, which is a nationally and state representative survey of the U.S. population. They also incorporate additional information from other surveys, so from the Census Bureau's Current Population Survey, they pull in additional demographic, income, and work information, for example, and then they pull in health care

spending from other sources, including the sources you see there, the MEPS-HC and the National Health Expenditure Accounts.

So what is it that we are sponsoring additional capacity in the model for? Well, again, their current model is based on surveys of individuals, and you can imagine that individuals may know whether or not their employer offers coverage. They may know what they pay out of pocket for that coverage, but they may not know, for example, or be asked in the surveys as a result, "Well, is family coverage offered, and what would you pay out of pocket for family coverage?" or, "Is there an offer of employee-plus-one coverage, and what would your out-of-pocket be for that?"

So what we find is that employers know that information a lot better than individuals do, and the approach that we want to use here is then to merge on what employers report for the workers, so that we have a better sense of what are the premiums that people would face, particularly in the post-CHIP landscape. So if CHIP ends and the parents are offered coverage, how much more would it cost them to enroll their children in that coverage? So that is why we are merging on this additional information, which is from the Medical Expenditure Panel Survey. The insurance component really should be called the employer component, so it's called the MEPS-IC, and that is from the Agency for Healthcare Research and Quality, and AHRQ has been helping tremendously, collaborating with the Urban Institute to help them get the best possible estimates included in their model.

So, as of today, because of the herculean effort that is required in enhancing the model, we are only able to release estimates of the sources of coverage for which separate CHIP children would be eligible in a post-CHIP landscape. Work continues to estimate the cost of coverage in the post-CHIP

landscape and whether children would obtain other coverage or become uninsured.

So I'm going to show you two pie charts, but I wanted to talk to you first about who the children are in each of those pie charts.

Number one is -- the first one will look at the approximately 4 million children who are projected to be eligible for separate CHIP in 2016, if CHIP were fully funded. So that is going to exclude children who are enrolled in job-based coverage because those children are not eligible for CHIP, but it is going to include children who are in their state separate CHIP income range who are either enrolled in CHIP or private non-group coverage, excluding exchange coverage, or who are uninsured.

Secondly, we are going to look at the approximately 3 million children who are projected to actually be enrolled in separate CHIP. Now, you may have in your head the 5.3 million zero to 18-year-olds who we have been saying are enrolled in separate CHIP and look at this 3 million number and wonder why it's different.

So here's why it's different from what we typically say. Number one is the Urban Institute looks at the number of kids at a point in time. We at MACPAC, our numbers typically publish the number of children who are enrolled ever during the year.

So let me just give a simplified example. Let's say we are looking at three children. The first is enrolled for the first half of the year. The second is enrolled for the second half of the year, and the third is enrolled all year long. So our MACPAC number would say there were three children enrolled in CHIP. At some point during the year, they touched the program. But for Urban's purpose, they would say, "We're looking at a point in time. At any point in time, we've got two kids enrolled." So, really, we're

looking at the same kids but a different snapshot. That's why the number is different there.

In addition, we are seeing the situation on the ground change in terms of a historic shift from separate CHIP coverage to Medicaid expansion CHIP coverage, one, because of California changing from separate CHIP to Medicaid expansion, so that just has a big impact, and then we have changes in the ACA because of the adoption of modified adjusted gross income and the stairstep children. So those kids who were between 100 and 133 percent of poverty, 6- to 18-year-olds, who were previously covered in separate CHIP programs, the ACA said, "You have to cover them in Medicaid, although you can continue to get CHIP funding for them." So those are some of the changes that have been taking place.

All right. Having said all of that, here is Figure 1. As in prior estimates, most children who are eligible for separate CHIP are projected to be ineligible for exchange subsidies in a post-CHIP landscape. So this is actually the pie chart that is comparable to what we had in our June report. So this is essentially the same group of kids, those who are eligible for separate CHIP, and the findings are very similar.

Again, all of these children would be eligible for something in a post-CHIP landscape. The question is, Would they be able to afford it? Would they enroll? So that will be what we look at in the next meeting, but for now just to say that most kids would be ineligible for exchange subsidies.

And the additional piece that we are able to look at now with the additional detail in the Urban model are these small wedges, that 4 percent of these children would be eligible for exchange subsidies, that the employer-sponsored coverage is not considered affordable according to the ACA's definition, which is even based on the self-only affordability test, so a fairly high bar, but still children, 4

percent would be able to get QHP subsidies.

And then in addition, there is another 2 percent who even though the parent is offered ESI, that is not available to dependents.

The second figure then is among children projected to be enrolled in separate CHIP. Pretty much the same story, the majority would be ineligible for exchange subsidies.

So then our aspirations for the next round of projections, which would be provided in the January meeting, would be to look at, if CHIP ends among children who are in separate CHIP, what is the distribution of premiums and cost sharing that these families would face for exchange or job-based coverage, and then based on that, how many would enroll in that coverage versus become uninsured, and then what are potential effects of some policy options, such as altering the ACA's self-only affordability test, also known as the "family glitch," or permitting children who are below 200 percent of poverty and ineligible for Medicaid to obtain enhanced exchange subsidies, just as a couple possible examples.

So, again, in this session, we wanted to provide you with an update on where we stand with the modeling, the post-CHIP landscape, to give you an overview of the model and the estimates we currently have, and where we hope to be at the next meeting. So I'm happy to take any questions and comments that you have.

CHAIR ROWLAND: Donna, then Andy.

COMMISSIONER CHECKETT: Andy and I were whispering over here, which we're not supposed to do, but we were actually extremely interested in one of your slides, so this may be what you're going to ask.

The situations where you have a working parent who has been offered ESI, but that ESI is only available to the employee, so the employer chooses, has the option to decide whether or not they are going to make insurance available to dependents, spouses, et cetera, what do we know about the -- not so much the employer, but those employees? So are those typically -- I mean, I've got my own thoughts, but I don't know, factually. Are these small employers? Are these low-income workers? I'm going to guess that any company that's employing people in 50 states for the most part isn't going to be offering that. In other words, a large national company isn't going to be offering that type of insurance.

But I'm curious about it because it could really drive some discussions about knowing the income, average income of those employees, that really fits into the whole debate about should we or shouldn't we not, making recommendations to address that, that situation where a child has no access, because you have a parent who is actually, I am thinking, probably a low-wage parent.

So I will stop there, if my question is clear.

COMMISSIONER ROSENBAUM: Can you just clarify? Are you asking about an offer or an affordable offer?

COMMISSIONER CHECKETT: Great distinction. I actually would say I am interested in what do we know at all because I don't know that we know much, but Sara is putting a good point on it.

COMMISSIONER RILEY: And it seems to me that there is a follow-up there around the SHOP and how many of these come from small businesses and when small businesses can be 100 and not just 50. I mean, there may be a differential there, where if we focus on the SHOP benefit, we may gain access for kids disproportionately than to the full ESI benefit.

MR. PETERSON: Yeah. That's a good question, and I could add my own speculations to that, but I don't know what the real answer is off the top of my head. I do feel like it is a small-firm kind of issue.

But you see that it is relatively a small number of kids who are affected by that particular issue overall, so only 2 percent of separate CHIP children would qualify for the exchange subsidies, because even though the parent is offered, the children are not.

But we can follow up, and we will get back to you on that.

COMMISSIONER CHECKETT: Yeah. I was just curious if we have any more information about it, and Trish, I think, also is raising a question about SHOP. Granted, it is certainly a small number of children, but it does speak to this broader alliance. I think we have an assumption that employer-sponsored insurance is going to be everything that we wish it would be when it isn't always, but thank you.

CHAIR ROWLAND: I think we will be able to, hopefully, get some of these answers when we have the next round of results from the Urban modeling.

Andy, then Patty.

COMMISSIONER COHEN: That was half of my question. I am going to ask one quick follow-up on that, which is, also, if there is anything that we can see in terms of trend -- I know 2 percent is a tiny number, but did it used to be closer to zero? Is that a growing number? I would not be surprised if it is. As the cost of health insurance continue to increase, that employers don't have a requirement to offer to dependents, it may be something that there might be change over time.

But my second question is, looking at the part of the pie chart that looks at children who would be ineligible for QHP subsidies because their parents are enrolled in ESI, about 34 percent, I am curious whether the simulation can tell you anything about sort of how much of their income actually would go toward covering their children, so we know it would be under -- what is it? -- 9.5 percent, because that would be the level at which they would switch to a different part of the pie chart. But what are the percentage levels? Is it 8 percent? Is it 2 percent?

Again, of course, that's going to be an on-average, but if you can get deeper than on average, that is really useful too.

MR. PETERSON: Yeah. And that is what we will definitely have because that is going to drive who enrolls.

COMMISSIONER GABOW: I think my question is quite naive, but I will ask it anyway. When you look at the parent enrolled in ESI, that 31 percent, and the parent offered but not enrolled, those kids are currently in CHIP. So doesn't that tell us that if we went to a non-CHIP world, it is very unlikely that these kids are going to take any other option? Because they didn't take -- they chose CHIP in the first place over the option of going into employer-sponsored health care. So they already voted with their feet, didn't they? And doesn't that tell us -- certainly, the economy isn't better now, and these people are still in the state they are.

So it just seems to me that we have a pretty obvious answer already. They voted already. They chose CHIP instead of these other alternatives, when CHIP existed. Maybe I am missing some really basic premise.

MR. PETERSON: No, I think that's fair, and I think what you're talking about, the parents who are offered but didn't enroll and potentially are uninsured, it could be because they found even the self-only part of their premium too expensive to enroll, and so what are the chances that they are going to enroll the whole family in a post-CHIP landscape.

Now, there may be some of them who say, "But I got to have my kid covered. I am fine to go bare," so that is where the modeling can help out because they can look at past experience and what the economics literature has said about people's take-up decisions. But this is going to be an issue where parents already are not enrolled.

CHAIR ROWLAND: But this is also a post-ACA world in which there is an individual mandate and a penalty if you don't enroll. So some of that has to be weighed as well.

David and then Sara.

VICE CHAIR SUNDWALL: I am just trying to think how this would be received on the Hill, and I think your projections seem to be just that, speculation. There is not much hard here. I am not very comfortable with these millions of kids. What is it? Two-thirds of kids on CHIP fall in this category? I mean, it's a large number, and you are speculating that this many would be uninsured based on --

MR. PETERSON: I'm not speculating how many are going to be uninsured.

We are waiting to see, once we have the actual simulations of how people respond to the prices that they face.

I hear what you're saying. I think the one good -- several good things about the way that

Urban does their modeling, and one of those is sensitivity analysis. So, in other words, I think your concern is, "Oh, yes. You could make different assumptions and come out with different answers," and what they do is they do analyses to say, "Well, okay. What would be the impact if we changed the assumptions in certain ways? Is that going to double the number of uninsured, or is it only going to increase it by 10 percent?" So they are very thoughtful about the way that they do this and note the variation that can occur based on those assumptions, with the hope that the numbers that we come out with will be within a relatively small range and are not going to be subject to wide variation depending on the assumptions used.

VICE CHAIR SUNDWALL: Well, I just hope that when we do this and when you finally get the better data that you are going to talk about in January, that it isn't misinterpreted as being yet another argument for continuing CHIP indefinitely because I think we don't know the landscape, what's going to happen with the implementation of the ACA as it continues.

COMMISSIONER ROSENBAUM: Chris, can you remind me, in the separate CHIP programs for that group of children, what is the average upper income cutoff in the states that run their programs separately? Is it at about twice the federal poverty level, or is it a little higher, a little lower?

MR. PETERSON: I feel like it's a little higher --

COMMISSIONER ROSENBAUM: A little higher.

MR. PETERSON: -- if you pick the median. It is going to be a little bit above 200.

COMMISSIONER ROSENBAUM: So, obviously, this number could grow if states, feeling the pressure about the declining or the potential for declining CHIP funds begin to ratchet back on

their eligibility -- the number may go down of the children affected, but that just means we have more children in a range where they could have been eligible for CHIP but are not.

CHAIR ROWLAND: Sara, there is the maintenance of effort until 2019.

COMMISSIONER ROSENBAUM: Yeah, but only -- that's right. So they can't cut down. They can only eliminate. They could only simply wipe out their separate CHIP programs, so there is no sliding backwards. They would just basically take a hike, if they wanted to, if they thought the money wasn't coming.

So, in other words, this is the -- I mean, I raise the point, mostly in response to David's question, because I think what we are dealing with here is sort of this moving target of millions of children caught. Based on what we know about CHIP today, this is the group of children caught in the family glitch who happen to fall into the world of CHIP, but this number of children potentially exposed to no insurance coverage could grow much greater if a state decided to simply eliminate a separate CHIP program and not move children into Medicaid.

I worry that we have a world in which people are not looking at all children who face problems in the family glitch as a group, okay? This is that part of the group that faces the family glitch and happens today based on current policy to be eligible for CHIP, but nothing about the maintenance of effort provision is going to protect these children if states faced with the loss of CHIP funding just basically move away from a separate CHIP program entirely. Then the number grows, and I don't think it would be the position of our Commission that, therefore, we don't have an issue because they are no longer eligible for CHIP.

I think in talking about the problem, we might want to talk about the problem, is the world of children affected by the family glitch, some of whom today are enrolled in CHIP, but by no means all of them. So I wondered if we could get sort of the bigger picture. You've given us the picture of that slice of children who happen to be in CHIP, but the actual number of children we could be worried about is actually much greater. They are potential CHIP children, just not there today.

COMMISSIONER CARTE: That's right. Sara is correct that even though there is the maintenance of effort -- in my state, we said that if federal funding is not forthcoming to sustain the CHIP, we will have to shut it down.

COMMISSIONER ROSENBAUM: We don't have to worry anymore.

COMMISSIONER CARTE: And it's not a matter of choice.

COMMISSIONER ROSENBAUM: Right.

COMMISSIONER CARTE: It was built in by our state's legislature --

COMMISSIONER ROSENBAUM: Right.

COMMISSIONER CARTE: -- into the statute that created it.

COMMISSIONER ROSENBAUM: I don't mean to confuse matters here, but I'm just trying to make it clear that, in my view, this Commission's concern is with a group of low- and moderate-income children who are caught in this potential problem. Many of them are eligible for CHIP today, but that picture could change very quickly, in which case we have two choices. One is to say, well, we're the Medicaid and CHIP Payment and Access Commission and so they're not CHIP children anymore, but my preferred way of our thinking about it is to see the children as a group and note that CHIP -- the

CHIP eligibility standard is a somewhat moving target because the maintenance of effort provision is not airtight.

COMMISSIONER CARTE: That's right, Sara, and maybe going forward, we'd be the Medicaid and Children's Access Commission, right? But -- and, I think something that sometimes can be lost in all this, the family glitch is the first problem, the first cut, you know, will insurance be available to children? But, then, the second cut is what is available? Is it affordable?

COMMISSIONER ROSENBAUM: I think that's right. The other thing is that while the maintenance of effort provision is here, I don't think -- in the separate state programs, it wouldn't prevent the state from dropping its eligibility standard. You can't -- if you have a Medicaid expansion CHIP program, then the maintenance of effort provision applies. But, if states see the money dropping off, I would assume that a state that has set its standard at 300 percent of poverty today might start downshifting its coverage, and there's nothing about the maintenance of effort provision that would require a state to keep spending at a rate faster than the federal government is supplying funds.

MR. PETERSON: Right. So, the separate CHIP programs can limit -- notwithstanding the MOE, they can limit enrollment to that population for which they have money. So, our assumption and the way that the modeling is done is to look first at, and what we've shown here is, okay, who is eligible, based on current practice --

COMMISSIONER ROSENBAUM: Right.

MR. PETERSON: -- and then we're looking at the separate CHIP kids, in particular, because the assumption is once the money ends, CHIP ends for those kids. So, that is what we're looking

at. Just, I want to make that clear. We're assuming that they're -- we're not taking into account the possibility that states would expand Medicaid to pick up those kids or anything like that. We're saying, what happens? Assuming the separate CHIP ends, what next?

CHAIR ROWLAND: Sara, isn't your point there are other children who are now being covered in employer-sponsored coverage that have high cost sharing and all the other things, aren't we also going to look at, if CHIP ends, what happens more broadly to children's coverage in employer-sponsored coverage, as well?

COMMISSIONER ROSENBAUM: Yeah. I mean, my concern is -- you're absolutely correct. My concern is that under the Affordable Care Act, we have now declared that four times the federal poverty level is an area of family income that is low enough so that, as a matter of public policy, we have decided that families need help. The snapshots we can take and the estimates we can do, of course, even when they're wonderfully sort of updated and refined the way you're talking about, are always going to lag behind.

We're chasing after sort of this moving target of degrading employer contributions to family coverage, stagnating wages so that even if the contribution remains, families can afford less and less, and states, given the tool of CHIP but a great uncertainty right now about the continuation of CHIP. So, it seems to me when we, as the Commission that was set up to be concerned about low- and moderate-income children and their families -- and you're absolutely correct, Sharon -- that as we talk about these issues to Congress, I think it would behoove us to show that there are these moving targets all the time and that the numbers may range from -- you know, we can take a snapshot and tell you a year ago, with

some certainty, what the number might have been.

But, we can tell you, moving forward, that the number -- I can't see it getting better. I can only see it really getting worse. That is, as the money begins to end or the threat of money ending in CHIP grows larger and the cost of health care continues to go up, I don't see any combination of factors that is going to make our estimates lower. If anything, the estimates will end up higher of the children affected, so --

And, the upper -- I know that CHIP really doesn't have, technically speaking, an upper limit, but there is a point at which Congress is essentially disincentivized, and that's over 300 or -- over 300. So, in that sense, you know, we could say that our concern is with children up to 300, but I think the Affordable Care Act would allow us to maintain credibility and say we're looking at the world of subsidized children -- potentially subsidized children, generally.

CHAIR ROWLAND: Well, I think we have a lot of expectations for the modeling effort that is underway, and I'm sure at our next meeting all questions will be answered by the models.

[Laughter.]

CHAIR ROWLAND: It'll be like the magic box.

So, we're going to turn now to continue our discussion of affordability of coverage for children moving from CHIP to the exchange, since affordability is really part of what we know is required to assure access to coverage, and Joanne's going to come back and be joined by Rob. And, now, we're going to flip back to Tab 2-B.

SESSION 1B

AFFORDABILITY OF COVERAGE FOR CHILDREN MOVING FROM CHIP TO EXCHANGE COVERAGE

* MS. JEE: So, first, as Diane said, we're going to continue our conversation from the last Commission meeting on affordability of coverage for children who may move from children to exchange coverage, possibly if CHIP funding is not extended.

First, we're going to review the exchange premium and cost sharing rules, which also apply to children. We have talked about these rules before, but we thought it important to touch on these again because they are central to your consideration on affordability. Next, Rob is going to compare an average CHIP and QHP premium and cost sharing experience for a family. And then, following those examples, we'll outline some options for addressing affordability of exchange coverage for this group of children.

So, there are two forms of subsidies on the exchange. The first is premium tax credits and the second is the cost sharing reductions. We'll start with the premium tax credits.

Qualified individuals with household incomes from 100 to 400 percent of the federal poverty level can receive a premium tax credit to lower what they pay for their QHP premium. The premium tax credit is the difference between the premium of the second-lowest cost silver QHP and the family's premium contribution. The family premium contribution is determined as a percentage of family income, ranging from two percent to 9.5 percent, and that's regardless of the number of family members enrolled in the QHP. And, the family contribution is the maximum payment that the family would be expected to make toward a premium for the second-lowest cost silver QHP in the exchange.

This line graph here just provides the values for those family contributions. And, again,

this is for a family of three in the second-lowest cost silver plan. And, you'll see that as household income increases, so does the family's maximum premium contribution.

So, what happens to family premium payments if a child moves from CHIP coverage to QHP coverage? For some families, there is likely to be little or no increase in what they pay toward the cost of their QHP premium because of adding a child to that coverage. These families include those with parents who are already enrolled in the QHP and who receive a tax credit to help pay for that QHP premium. And, those with premiums for whom the -- and those for whom the premium for the parent-only QHP exceeds what the family's maximum premium contribution amount would be. So, those families are paying up to their -- this is, again, for the second-lowest cost silver -- the families are paying up to their maximum premium contribution, but the cost of the premium for the QHP actually is higher than their contribution, so then the tax credit kicks in and makes up the difference.

Some families will, however, see an increase in what they would pay toward the cost of their premium. Those families include those with higher incomes, because those families have a maximum family contribution that would exceed the cost of the QHP, and families with just one parent. For these families, the cost of parent-only coverage would be less than the cost of the coverage with the family.

EXECUTIVE DIRECTOR SCHWARTZ: And, Joanne, I know it's in the paper, but can you remind us, for that three-person family, where that cut-off is for the higher -- the premium.

MS. JEE: Right. So, the cut-off really depends on income and sort of what the person looks like and the plan. But, if we look at the second-lowest cost silver and we look at an adult, a 35-year-old adult, that cut-off would roughly be 332 percent of the federal poverty level.

Exchange cost sharing reductions are another important concept that we'll just briefly touch on here, and I'll ask you to keep them in mind as Rob runs through the examples. Cost sharing reductions are a subsidy available to those purchasing silver tier QHPs and that have incomes from 100 to 250 percent of the federal poverty level. Enrollees who receive the cost sharing reductions pay less in cost sharing, such as copayments, coinsurance, and deductibles, and they have lower out-of-pocket cost sharing maximums than those without the reductions. The ACA sets the maximum out-of-pocket limit based on income, and that's what's shown in the third column of this table.

So, for example, looking at the chart, a family with income at 151 percent of federal poverty level would buy a QHP with an actuarial value of 87 percent. So, this means that the QHP would pay for 87 percent of the cost of covered services and the family would pay 13 percent, up to a maximum of $4,500. And, once the family has hit the out-of-pocket max of $4,500, the QHP would begin to pay for all of the costs of the covered services. So, the AV is a measure of how much the plan pays, on average, for the cost of covered services. The higher the actuarial value, the more the plan pays and the less the family pays.

And, just as a reminder, there are plans on the exchange with higher actuarial values, and that's provided in the last bullet here.

So, I've given you an overview of premiums and cost sharing subsidies in the exchanges and I'll turn it over to Rob to walk us through some examples.

* MR. NELB: Thanks, Joanne. So, as Joanne reviewed, there are a lot of different rules and complicated actuarial values and things that you're all aware of. But, to help kind of put this in context, we thought it would be helpful to walk through a hypothetical example of how this would actually

play out for a family in CHIP in QHP coverage at two different income levels.

This example draws from some data that you've seen before, some cost sharing data from the Wakely Consulting Group, which we discussed at the last meeting, and also adds premium data from the National Academy for State Health Policy. By looking at premiums and cost sharing together, we hope to give you a fuller picture of a family's overall financial impact.

Now, three caveats before I begin. First, not all families are average. The example I'll be presenting looks at average cost sharing for a hypothetical family, but actual cost sharing will vary depending on a family's health care utilization. A family with special health care needs, for example, will pay higher cost sharing.

Second, not all states are the same. This example presents an average of separate CHIP states, but within those states, there is, of course, wide variation in current CHIP premium and cost sharing policies. Some states have no premiums and cost sharing in their separate CHIP programs while others have premiums and cost sharings that get close to the five percent maximum of family income, which is the limit in current CHIP statute.

And, finally, not all QHPs are alike. The example I'll be presenting is for that second-lowest cost silver plan, but there are other QHPs available on the exchange, including gold and platinum plans, which have lower cost sharing but higher premiums.

All right. So, let's begin. So, again, this example is looking at a hypothetical family of three -- that's two parents and one child -- at two income levels, 160 percent of the FPL, which is about $32,000 a year, and 210 percent of the FPL, which is about $42,000 a year. And, remember that most

separate CHIP children live in families with incomes below 200 percent of the FPL. But, we thought it would be good to present the higher income example to show you the range of potential family experiences.

Now, to make sure we're comparing apples to apples, we'll be looking at the cost of CHIP coverage for the child compared to the cost of QHP coverage for the child, which we'll be calculating as the difference between the cost of family coverage versus the cost of parent-only coverage. So, we're looking at that marginal cost of adding one child to a family's QHP plan.

All right. So, first, we'll look at premiums. In this hypothetical family, the CHIP premium would be $92 a year at 160 percent of the FPL and $319 a year at 210 percent of the FPL. For QHP coverage, for the child, there is no marginal cost for adding a child to the QHP plan, because in both examples, the family would have already been paying its maximum premium contribution for the parent-only coverage, and, so, as a result, the tax credit for the family would increase to cover any additional cost for the child.

Next, we'll look at cost sharing, which is the red bar in this example. Again, remember that this represents the average cost sharing, which is the function of a plan's actuarial value, and that the actual cost sharing faced by a family will vary depending on a family's health care utilization.

Here, CHIP performs better than QHP coverage. At 160 percent of the FPL, the average annual cost sharing in CHIP would be $117 for this family, compared to $446 in the exchange. At 210 percent of the FPL, the average annual cost sharing for the child would be $204 in CHIP, compared to $926, on average, for the child in the exchange.

When you look at, the total average cost to the family, looking at premiums and cost sharing

combined, CHIP also performs better and QHP coverage is about twice as much as CHIP coverage.

To complete our picture, we'll look at out-of-pocket cost sharing maximums to get a sense of the total potential financial exposure that a family could face. The dotted line on this graph represents the sum of the premiums plus the out-of-pocket cost sharing maximum that a family might face. In some ways, it represents sort of a worst-case scenario for the family, if they pay their premiums and then also reach their max in a given year.

At 160 percent of the FPL, that total potential financial exposure in CHIP is $536 a year, and in exchange coverage for the child, that total potential financial exposure is about three times as high, estimated at $1,619 a year. At 210 percent of the FPL, we see a similar trend. Adding in that out-of-pocket cost sharing max, the total potential financial exposure in CHIP is estimated at $1,297 a year. In the exchange, for the child, it's, again, about three times as high, $4,162 a year.

So, what does this tell us? First, we see that CHIP is more affordable for families than QHP coverage, even after premiums are taken into account.

Second, we see that this effect holds at both income levels, although the absolute magnitude of the change is greater for children at higher income levels.

And, finally, we see that the change due to that out-of-pocket cost sharing maximum is where the biggest change is that the families will face moving from CHIP to QHP coverage.

CHAIR ROWLAND: Rob, in terms of clarification, obviously, the out-of-pocket maxes in CHIP apply only to coverage for the child. When you get into the QHP, any member of the family can contribute toward that out-of-pocket max?

MR. NELB: Correct. To help --

CHAIR ROWLAND: So, you could be picking up the cost sharing for a parent, as well.

MR. NELB: Yeah. Again, to sort of isolate the impact of the effect on a child, we compared the costs with the family plan versus the individual. So, in the exchange, there are sort of two different cost sharing out-of-pocket maximum limits. One is for the family coverage and one is for individual. This chart represents sort of that marginal increase in the out-of-pocket maximum, and so the out-of-pocket maximum for the entire family would actually be a bit larger than what's on this graph.

[Off microphone.]

MR. NELB: This is for -- for the child, is how I would phrase it.

COMMISSIONER COHEN: Is it okay if I just ask another clarifying question?

MR. NELB: Yeah.

COMMISSIONER COHEN: And, I'm sorry if I missed this. So, the reason there's no premium cost on here is because the whole graph assumes that this is adding a child to a family that's already on the exchange, that's already, like, maxed out their --

MR. NELB: Yeah.

COMMISSIONER COHEN: Okay.

MR. NELB: Yeah. So, just a -- the number is here, but, for example, the family at 160 percent of the FPL, I think, would be paying about $1,400 for their premium for the parents, but the unsubsidized cost of exchange coverage for the parents is about $6,900, so they're sort of well over it just with the parent coverage. So, adding the child doesn't make a difference.

And, actually, one other point I just wanted to make, sort of glossed over, you may notice that in CHIP, as I mentioned before, most states have cost sharing that's below the five percent max of family income, which is the statutory limit in CHIP. Just to sort of put that in context, on this graph, at 160 percent of the FPL, five percent of the family's income would be about $1,500, which, again, is sort of more than what most CHIP plans charge, but is sort of less than what we estimate in the exchange, and the same trend sort of holds true at 210 percent of the FPL.

I'm happy to answer more questions as we get to the discussion, but I'll turn it over to Joanne to again discuss some possible policy strategies.

MS. JEE: So, to improve affordability of coverage for children who might move from CHIP to the exchange, premiums, cost sharing, or both could be addressed. Lowering premiums would help families purchase and enroll in a QHP. This would help those families that would see an increase in what they would have to pay for their premiums by adding a child -- for adding a child to that QHP coverage. It would also help families for which the QHP premium might just be too high and they might choose to forego coverage, but additional assistance could help them, both the parents and the children, be enrolled.

Families that may want to purchase plans with lower cost sharing but that have a higher premium may also benefit from additional assistance with premiums.

Reducing cost sharing may improve children's access once they're enrolled in the QHP. As Rob explained in the examples and as he has discussed in previous meetings, children and families will face substantially greater cost sharing in the exchange in comparison to CHIP. So, lower cost sharing would

help most families, but especially those who have greater use of services.

We think that there are two primary mechanisms to address premiums and cost sharing, or both, for children in this population. That would be providing wrap-around subsidies, which, as many of you know, is not necessarily a new concept. And, the second would be enhancing the current exchange subsidies.

So, to turn to premium wrap programs, to provide you a couple of examples which we thought would be helpful. Four states -- Massachusetts, New York, Rhode Island, and Vermont -- are using Medicaid funds to provide a premium wrap-around to help with the purchase of QHPs, and this is for the adults who were previously covered under a state Medicaid program. There are additional details on these states in your packets, which we won't go over, but I just wanted to highlight that these additional premium subsidies work in tandem with the premium tax credit already available on the exchange. And, just to keep in mind that these programs are relatively new and so there's still a lot to be learned about how they are being implemented in the states.

Additionally, Medicaid and CHIP programs have provided premium assistance to help purchase employer-sponsored insurance. These programs differ, and some pay for all of the costs of the premium, a portion of the cost of the premium, or a set dollar amount. Many states have implemented these programs, but in general, enrollment has been relatively modest and there hasn't been that much reported as to their effectiveness.

The states, though, have reported on some challenges with operating premium assistance programs that would be important to consider. For example, it can be difficult to obtain the needed information

from health plans. There may be high administrative costs associated with operating a premium wrap-around program. And, there can be difficulties in outreaching and educating the various stakeholders, including the families and the plans.

There also are models for providing a wrap-around subsidy on cost sharing. In the Arkansas and Iowa private option, where the state purchases exchange coverage for the Medicaid newly eligible adult population, the states are purchasing qualified health plans on the exchange with high actuarial values, and these are plans that were already on the exchange, so they didn't create a new plan for this population. The plans pay for a greater cost of the care and the enrollees a lower cost. The programs also pay for enrollee cost sharing once their cost sharing has exceeded five percent of their family income. And, again, just a reminder that these programs are relatively new and we continue to learn more --

Some Medicaid and CHIP programs also have provided wrap-around subsidies for cost sharing, and some have done this by providing separate cards, Medicaid cards, for cost-sharing expenses, and others have required enrollees to track their cost sharing and then to submit and request reimbursement for that cost sharing. So you can see that there would be some operational challenges around providing a cost-sharing wrap.

So the current exchange subsidies also could be enhanced to provide greater assistance to children who move from CHIP to the exchange coverage. An enhanced subsidy could build upon the existing infrastructure for the premium tax credit as well as the cost-sharing reductions.

With respect to premiums, the premium tax credit could be increased so that the federal government pays for a greater share of the QHP premiums, and the enrollee premium contribution amount

would be reduced. A premium subsidy could also allow families to purchase those plans with a higher actuarial value which would have the added benefit then of lowering their cost sharing.

Cost-sharing reductions also could be increased for this group of children. Specifically, the actuarial values of QHPs could be increased, which would mean that the plans would cover more of the cost of care, and enrollees would have reduced cost sharing.

Lowering the out-of-pocket maximum would limit families' potential financial exposure. Families would pay less in total in cost sharing for the cost of their care.

And, finally, cost-sharing reductions could be provided to those families who have incomes greater than 250 percent of the federal poverty level. Currently those families are not receiving cost-sharing reductions.

So we've given you a lot of information, and we would ask for your feedback, Commissioners, on the questions that are here on this slide. Does the Commission want to address premiums or cost sharing or both for these children? Would a new wrap-around program or changes to current exchange subsidies be the most effective approach? And which children would qualify for any additional assistance? And what, if any, threshold level of enrollee spending would be expected before any additional subsidy is available?

Based on your responses, Commissioners, we'll go back and flesh out some options a little further, including looking at the impact of them on state and federal governments as well as on enrollees and the health plans.

CHAIR ROWLAND: And let me be clear here. We're not just looking in these options

at children who are currently covered by CHIP. These would be provisions that apply to all children within that income range.

MS. JEE: Well, I mean, I think that is a question. They could apply -- they could be targeted specifically to children in the CHIP income range, but I think it's important to keep in mind that, depending on the option, you know, there could be a broader effect.

CHAIR ROWLAND: Because I think that, you know, we have the issues of how to make sure that the children who have been covered by CHIP are not worse off by the changes that are going forward. But I think as a Commission what we really ought to be looking at is what is the level of cost sharing that children's families can bear and that we don't want to create a kind of privileged class of children just because they were covered by CHIP, they get to have a different set of cost-sharing or premium assistance in the exchange than another child in a comparable family situation who just didn't obtain CHIP coverage or who lived in a state with a more limited eligibility level for CHIP.

Okay. I'll start with David, and then I'll go to Judy -- I'll go back and forth.

VICE CHAIR SUNDWALL: This has generated a lot of discussion. Thank you. That was a lot of information and very -- [off microphone].

This is a huge issue, meaning in general, talking not just the CHIP population, but this premium subsidy -- I mean, the family share is what has been a big point of discussion in Utah as we consider expanding Medicaid, and been contentious with the back-and-forth efforts to get a waiver from CMS or from HHS.

I must tell you that, from a conservative point of view, I sit here and say, "How much is

enough?" We have already expanded insurance coverage under the ACA incrementally for many, many, many people. Whether or not it's enough I guess is always going to be debated, what degree of cost sharing or exposure, as you call it, they can handle.

Now, I understand that this is currently just a waiver in certain states that have chosen to do it and experiment with these. I guess my caution here is, as a Commission, I think it's important we report on these activities and make sure the public is aware of what's going on. But I would be careful about endorsing yet more subsidies.

What I heard today was this is yet another layer of complexity, yet another administrative overhead cost. These are all things that we want to get away from. So while I appreciate the sincere efforts of people to help families within this, I think it is questionable that we would want to yet propose another wrap-around -- or two kinds of wrap-arounds to address this issue.

Anyhow, I just wanted to caution on that aspect of what you're talking about.

CHAIR ROWLAND: Okay.

COMMISSIONER MOORE: I wanted to echo a bit what Diane was suggesting about our deliberations around dealing with this issue in the context of all children within whatever low-income category we define, primarily because I think we should address in that context simplicity, consistency, and uniformity, which have been some of the approaches that we've talked about over the five years that we've been meeting. And it seems to me that if you start treating children who had CHIP but now don't differently from children in the same income bracket or family situation differently, then you've vastly complicated the administration of these programs so that I think we want to treat all children -- and we

want to spotlight the needs of low-income children for continuing high-quality, helpful health care coverage, just as a larger -- a big-picture item to think about.

CHAIR ROWLAND: Judy, I think a simple way of stating it is we're not intending to grandfather CHIP children and to have --

COMMISSIONER MOORE: Yes, yes. There are plenty of grandfather --

CHAIR ROWLAND: -- trying to figure out how to best provide affordable coverage to children.

COMMISSIONER MOORE: Right. In the new world of ACA, I think we need to try to get away from grandfathering. There are so many provisions like that in the past that just complicate Medicaid and children's coverage enormously.

CHAIR ROWLAND: We don't want them to be called the "MACPAC children."

[Laughter.]

COMMISSIONER GABOW: Thanks. This is complicated, and I have four comments. Three I think are serious caveats as we go forward. One is just a minor thing.

The first one is that I believe -- and correct me if I'm wrong -- that these data that you provided are based on the belief or using the construct that the benefit coverage would be the same. If, in fact, the benefit coverage would be less in the QHP, say no dental, for example, and the children still need that care, that would be an additional out-of-pocket expense for the family that is not included in the maximum out-of-pocket expense. So that is not trivial. So I don't think we can ignore comparability of benefits when we're looking at the cost.

The second issue which I think we really need to think about and putting it in the context of

much of what we do is there is data that I think is rather good about what, in fact, is the disposable income of a family at a certain federal poverty level. I mean, they have to pay for housing, food, clothing, transportation. So I think looking at what is available at these levels realistically to contribute is very important, because if there is no money left over after you've paid for all those other things, you can -- what does it mean?

And in that regard, I think in trying to understand what we're talking about, about affordability, it seems to me it would be useful to understand what this would look like if we were asking the same of Medicare recipients. Or what if we were asking the same of people over $100,000 a year income who were on employer-sponsored coverage, what would we be asking them to contribute?

I mean, somewhere we need to think about are we asking more of our poorest and our children than we're asking of our seniors and our people who are lucky enough to have employee coverage. Maybe we're not. I don't know those data. But it just seems to take it completely -- if we take it completely out of context of the whole American population, we're missing something important in this dialogue that I think we could contribute. And maybe it's not different. I don't know. But I'm just saying should we have more context.

The third issue that I worry a lot about -- and maybe others know more about -- I'm sure others know more about it than I do. But when we say that we're going to limit this to 5 percent of family income, does anybody have a clue of the reliability by which that's administered? I mean, given the discussion that we've had about the administrative robustness of the Medicaid program and how people at this income level move all over the map, depending whether they're at McDonald's this month or Walmart

the next month, or whatever, I mean, I don't think I could keep track of what 5 percent I'm spending of my income. And I know it's not the responsibility of the families but of the program. I've never seen any data about how reliable that is, so when we base something on that number, shouldn't we know whether that is actually reliably done?

And the last thing is just a little nit, but why did we pick three when like just one child -- my guess is the mean number of children on CHIP in a family is more than one.

PARTICIPANT: [off microphone] six.

COMMISSIONER GABOW: Well, I know, but shouldn't we pick the mean? Or the median?

EXECUTIVE DIRECTOR SCHWARTZ: [off microphone] six.

COMMISSIONER GABOW: So that it seems to me that just picking a number is not as good as having a reason for picking the number.

COMMISSIONER COHEN: Thanks so much. This work was really good and I thought teed up the issues incredibly well -- maybe with one exception of something I want to add in, but I thought I would start by just saying I think -- I hope I'm not leaping out on a limb here to say it does seem that we are interested in addressing premiums, cost sharing, or both. I think we don't quite -- I don't think we have enough information now actually to sort of know whether a wrap -- like which mechanism is the better mechanism. I think we need maybe some more work on that.

For one thing, I know wrap-arounds and premium assistance in Medicaid has been, I think in most states, a program where it's like one person has their idiosyncratic offer -- you know, idiosyncratic

insurance plan offered by their employer, and, you know, it's completely sort of out of this system of how Medicaid eligibility and coverage is done, and each, you know, policy is different. And you know what I mean. It's understandably, from an administrative perspective, incredibly cumbersome, but if you had QHPs, which are sort of standardized and otherwise, you know, it might -- and there are a fewer number of them, it might be a very different thing. So I think past experience may not be that useful for sort of thinking about the future in that regard.

The issue that I wanted to raise, which isn't in here, although maybe it's implicit and I'm kind of missing it, I think there is a question with tradeoffs about whether or not we are talking about improving -- addressing issues around cost sharing for families with children or for the children within those families. And I do think that's an important question for us to think about because I do think that there are probably significant complexity tradeoffs to trying to change something for the children within a family policy. And, of course, you would be potentially losing some benefit for the adults.

On the other hand, CHIP is a targeted program to children. I think our concern is primarily targeted to an adult's decision. What is too expensive to bring your children to the doctor or otherwise? And I just think we really need to grapple with that one in particular, whether there is a way to target it and what would be the sort of costs and complexity or otherwise to do that.

COMMISSIONER HOYT: I don't know if this is a new comment or in support of what Judy and Diane said, maybe a clarification. I guess maybe coming at it a different way, none of this is simple, and if it was up to me, I would not do anything further with the cost sharing, the co-pays or deductibles, because at the point of service where a kid's receiving -- having a 'script filled or seeing a

doctor, going to the clinic, then you're really introducing additional layer of complication if it's, oh, it's one of these kids, you know, then this set of rules applies. It's fine if we want to financially support the kids making a transition from CHIP into QHPs. I would vote to do it in favor of premium assistance, the subsidies or a maximum out-of-pocket, but just keep it away from the providers, the managed care plans. You also have the additional ding sometimes, too, of then that money is never collected and they deliver the service and nobody gets the co-pay. So I guess that's my point of view.

COMMISSIONER RILEY: I guess I've been grappling with the -- we had a responsibility to think about these CHIP kids and how it all works, but I'm grappling with the bigger issue of affordability in these programs, period, in the ACA. So it's tough to kind of extract that. And I wonder if it might be interesting to think about the underlying costs, because it's awfully difficult to imagine in this environment a great appetite for more spending in the ACA. And yet that's what we would be requesting for the benefit of these children.

I wonder if there's a way -- I don't know enough about how separate CHIP programs negotiate and pay for plans and coverage and whether they set rates differently than the private market. So I wonder if there's some lesson that we can add to this discussion about how separate CHIP programs are paying for coverage. Is it cheaper? Are they setting rates the way Medicaid does? Or versus buying coverage in the private market, and there may be some way we can talk about the underlying costs.

COMMISSIONER WALDREN: Two comments.

One is I looked through all those questions and tried to figure out, okay, well, what's the impact of each one of those. And what I feel like -- since, you know, my day job is not in Medicaid, what I

feel like is when I -- I'm a data person. When I open up a spread sheet of a database file that has 30 or 40 columns and about a million rows, and I'm just looking at all this data, it's, like, all right, I've got to do something to visualize it. I think if we could maybe even think about even doing a project where we would get a consultant to help us from a data visualization standpoint, we talk about all these different populations, and sometimes we talk about 100 to 150 percent of poverty. Then there's one that's 160, then there's 210. And then we talked about, you know, different types of families, and it seems like we just have this potential of this branching map, being able to drill down and say, okay, here are all kids, how do they get separated out, and can you drill down to that one and start to drill down to smaller and smaller pieces?

Then for me at least, to be able to look at those questions and say, okay, well, that means that I would circle these places on this map and say these are all the populations that this particular question deals with, and then making that decision about what's now kind of more important. So if we could do that, I think that would at least help me, and I think people that are not doing Medicaid policy all the time, I think it would give them a good idea of what's going on and the magnitude and what would happen relative to that.

The other is just a comment that when Mark made his point about the co-pays and stuff like that, I don't think we have to do anything big relative to this, but just as a place holder and put in our road map as we move forward as we think about payment, there are alternative models for delivery and payment, so there's comprehensive primary care, there are these direct primary care where there's a monthly fee for primary care services, which starts to line up the provider with providing the right type of services for that patient no matter what they need. And it is, I think, a pretty cost-effective model, at least in the very

beginning. So thinking about that on the list. Again, I don't think we need to do a whole lot of work relative to that because it's still pretty -- you know, in its infancy. But put that on there as we think about something that how do we decrease the cost, because we're always talking about more and more coverage is more and more cost.

COMMISSIONER ROSENBAUM: Just a few additional points. I find the hardest part of all this to grapple with is that we've got these -- I hate the word but I'll use it -- two paradigms on the table. So in one paradigm, we have a program that has operated -- we were talking about this before with Chris -- on the expectation that if you are below 300 percent of the federal poverty level you'll receive substantial premium assistance and substantial cost-sharing assistance, and the actuarial value of your plan will be very high.

Now we have this other paradigm that says if you're below 400 percent of the federal poverty level, you receive premium assistance, which is more substantial the lower income you get, but we're not presuming any cost-sharing assistance really, if we wanted to be, you know, frank about it, above about 200 percent of the federal poverty level, because the premium assistance -- the cost-sharing assistance at that point is so de minimis that those families are not really helped.

And so I think the first challenge we have is where the combined -- Congress has created two policies, so the first question is: Which of these two general approaches do we think is the preferable approach? And the only way I can imagine doing that is by doing exactly what we're doing, illustrating for Members of Congress the financial effects of setting the policy at different levels; and separately then saying that, you know, there's this separate paradigm which is that children should get higher premium assistance

on the -- overall assistance on their own even if families don't get that overall assistance, going to Andy's point, which is you've got a second decision to make about whether or not we're going to, even within a family where the parents would only get assistance up to twice the federal poverty level, we're going to continue the favored CHIP policy, whether it's by continuing CHIP or whether it's by redoing the program.

An issue that I've talked through with my colleague Jenny Kenney, with whom we just did a paper for Health Affairs, is whether we also should look at the question, which I think is an important one to look at, and that is, whether, in fact, you can reduce the cost impact of having a consistently higher, more generous level for children by unifying the risk pool, and whether that unification of a risk pool down the line at the point at which there's a transition essentially allows Congress to continue some with the CHIP more favored treatment status with better benefits and with better cost sharing, with the dental problem fixed, because of the value of bringing some number of children -- we're never sure -- into the risk pool. Because I think that the -- I mean, the point that David Sundwall was making is I think an important one, which is how -- you know, all of this might require resources that we're not currently spending, but there are offsets. One would be the elimination of separate CHIP spending. One might be the changes that come to the premium subsidy exposure by unifying children.

So I think we've got to take these issues that you're briefing us on and sort of break them into a bigger presentation for Congress about the choices it has made, and it has made them back to back. You know, in 2009, they made the choice to go actually as high as states wanted for CHIP, but a favor -- you know, favored status at 300. And then in 2010, they made a different set of choices, and so what choice do they want? And in making that choice, they need to think about several moving pieces together: the

benefits, the unification of the risk pool, the cost sharing. And I do think Patty's point, I would assume that the way going forward it gets presented is not that you have to go through these crazy machinations of calculating 5 percent of income, but that you set a higher actuarial value on the premium that allows for more generous cost sharing.

So that way we're sort of taking a step back from our work and saying this is the picture, this is the way you should be thinking about this, and within that bigger picture here are the choices you need to make. And then we can play them out just as you're, you know, playing them out.

I do endorse the idea that we think about families of different sizes or a slightly larger family.

COMMISSIONER CARTE: Thanks for those comments, Sara. That kind of lays the groundwork for what I'd like to point out. And, Joanne and Rob, I'm sorry to say, but I think the answer to your first issue is that we really have to look at both, but I think a way to do that is to look at what Sara just said, the actuarial value of what a pediatric benefit is going to be. And I think we need to estimate that, and it won't do any good if we make premiums low enough or allow families that are currently in CHIP to be able to go into QHPs if once they go they can't access the service or they can't even afford it, even with a more subsidized premium.

So I would hope there'd be a way to get an estimate, just as when CHIP was brought up we had to benchmark that, you know, at a strong, robust level. The Secretary for HHS is still supposed to certify QHPs that have a minimum pediatric benefit. That has yet to occur. But I think this Commission should go ahead and look at what an actuarial value is and set a base level for that, and if we need a cost estimate on that, we should be asking for it.

COMMISSIONER EDELSTEIN: I'd like to second Sharon's recommendation, while recognizing the problem that Mark raised. As a former practitioner, the issue at the point of service is just terrific. Very difficult to deal with. You never know from one occasion to the next what the peculiar coverage is for that individual. And it just adds complexity to the whole thing.

So I think Sharon's recommendation to address it and Sara's recommendation to address it through the actuarial value of the plan is the most sensible way that the Commission can go forward with a recommendation.

COMMISSIONER ROGERS: I also think that I agree with Sara and Patty that we should look at family numbers being larger and income levels being lower because I don't think that the average income is $42,000 at all. I'm just thinking of what our administrative assistants make at my work and -- not going to happen.

COMMISSIONER CHECKETT: Really great discussion and great work. Thank you to the staff.

I am really circling back on the point of service issue. One of the biggest concerns I have about traditional insurance packages, including QHPs and some CHIP programs and others, are when we have to have a family go out of pocket to reach a deductible that is anything more than about $200. The truth is for families with marginal incomes and limited discretionary dollars, to pay $25 or $30 or whatever that amount is for an exam, it could frankly -- I know there's research that indicates and drives decision-making about whether or not children or anyone has access to anything less than the most acute need for acute medical intervention, and I think we can't lose sight of that when we look at the really critical aspects of

preventive care, especially for children.

Thank you.

CHAIR ROWLAND: You know, I think that what this discussion has opened up is not the discussion about moving CHIP children into qualified health plans, but overall what policies are in place, both in the Medicaid program, in some of the new waivers that the states are asking for the expansion population in CHIP and in the qualified health plans and even in employer-based coverage about what level of cost-sharing and what level of costs people can bear at different incomes.

So I think that you are opening the door to a much broader piece of work. We are going to talk later in this session, in this meeting, about the savings programs under Medicare and what level of cost sharing do you fill in on the Medicare program and how does that work.

So I think that this really is the beginning of a much broader and longer discussion, but you have set out a lot of issues. But I think we would want to consider all the things you want to consider, but we want to consider a whole lot more, and I think we really have said today that we want this discussion to be in the context of broader policy on affordability for low-income and moderate-income families that are getting their coverage, whether it be through Medicaid or whether it be through the qualified health plans or whether it be through what is now the CHIP program.

So thank you to the two of you. You've got a lot more work to do for us, and we're glad that you've done what you've done so far and opened the door to this discussion. And we look forward to continuing this discussion at the next meeting.

I wanted to have Veronica come up and at least also review for us some of the results from our

roundtable on pediatric network adequacy that will help us to understand even more about the implications of changes and coverage for children.

SESSION 1D

PEDIATRIC NETWORK ADEQUACY ROUNDTABLE: INITIAL THEMES

* MS. DAHER: Thank you.

So I am going to be giving a preview of some of the key themes that came out of this roundtable that we held on pediatric network adequacy that was December 1st. I am going to do a final report for you in January, so this is just a preview, a first look.

As you know, we have been talking about network adequacy as one of the keys to children's access to care, and it's one of the concerns that you all raised in your June 2014 CHIP recommendation.

As you know, the Commission recommended that federal CHIP funding be extended for an additional two years, during which time key issues regarding the affordability and adequacy of children's coverage could be addressed.

So we've often heard that CHIP networks are better than QHP networks because they are designed specifically for children, yet we have been talking about this, there's really little empirical evidence about the composition of these networks or how kids who transition might be affected.

So we wanted to explore these issues further, and we invited a diverse group of stakeholders to a roundtable discussion. The participants included representatives of state insurance commissioners; Medicaid and CHIP agencies; representatives of Medicaid, CHIP, and exchange plans; pediatric providers; beneficiary advocates; research experts; and CMS.

So we asked the participants a bunch of questions. Here's a good sample. We asked them about their main concerns about the adequacy of provider networks for children. We asked if there were significant differences in networks between QHPs, CHIP, and Medicaid. We asked about the effects of different regulatory standards on these networks. We asked about the unique needs of children, especially those with special needs. We asked if different standards might be needed for children and adults, and we asked if the current monitoring tools that are in place are working.

So here's what we heard from them. Well, first of all, while there were concerns about network adequacy for kids, participants were clear in their belief that the most pressing issues are differences in cost-sharing and benefits, and I think that reflects what we have been talking about as well.

A common refrain was that if kids are priced out of the QHP market or if the needed benefit is not covered, the network would be irrelevant to the child.

Participants were most concerned about how children with special needs would fare in QHPs versus CHIP, but a key theme was that regulations should be based on the most common needs of a population. And so participants believed that the percentage of CHIP kids with very complicated special needs is relatively small, but plans believed that they could meet the needs of those children if states, plans, and specialty groups could support the use of single-case agreements and greater care coordination.

Participants believe that it's necessary to focus on these very vulnerable children, but that it's hard to categorize them. There are many different special needs definitions, as you all know, ranging from SSI eligibility, to a child who has a chronic condition, or even sometimes just a child who takes a medication.

So participants had concerns about how network adequacy and access are being measured today.

They don't necessarily believe that the current standards are working for children or for adults, and they wanted to highlight that.

And we asked about how they worked for kids. They expressed frustration with currently used tools, such as provider directories, time and distance standards, and grievance monitoring. They did believe that secret shopper studies are a good way to measure provider availability, but they noted that these are expensive to carry out.

Some participants cautioned that families see provider directories as the key way to understand the product they are purchasing, but everyone agreed that accuracy of those directories is really a big challenge.

Grievances were called an imperfect and incomplete measure because many enrollees don't self-advocate.

Participants also believe that strict time and distance standards don't take into account the geographic diversity between states and within individual states. They also caution that in many areas, the maldistribution of providers, especially specialists, creates a surplus in one area of the state and lack of access in others.

To that end, participants believe that states rather than the federal government should take the lead in setting specific access measures, and in talking about these measures, participants would like network adequacy measures to take into account creative solutions.

When specialty or other providers are limited, plans said that they don't have the market power to create the network that they would like. Many believe that single-case agreements or use of telemedicine are the key to solving these issues, but they are concerned that current measures of network adequacy really

don't take all these different solutions into account.

In addition, state and federal regulations might limit the use of telemedicine or might limit an expanded role for primary care or other health professionals in certain situations.

So they supported empowering primary care providers in the community to be able to do more. Participants believe that primary care access is likely to be adequate in QHPs, but that specialty care may be what's lacking. Participants believe that supporting primary care providers to treat kids in the community, when it's evidence-based and when it's prudent, would be more convenient for the families and would lower the cost.

Support could take the form of education programs, telephone, or electronic consultation with specialists, or telemedicine. Others suggested incorporating provider surveys to measure if providers are able to refer to the necessarily specialists.

There was also a discussion about which measures are the most useful in monitoring access and outcomes of care as well as the burden on states and plans analyzing all the measures that they collect.

There was support for using multiple measures as long as those measures are woven into a big picture and are really linked to the results that we want to see.

While everyone agreed that regulations should set a floor, we didn't really reach a clear agreement on what the floor should be. We did hear agreement among the participants that a network is adequate if people can get the care that they need.

And lastly, they did recognize that there are tradeoffs between broad networks and affordable coverage, and we heard that it's very difficult to ask families to anticipate what their needs are going to be in

the future. Families are likely to choose a plan simply because it's lower priced, of course.

Participants raised the issue of consumer education, and so we heard "if you value things that people don't understand, you will price yourself out of the market."

Accompanying cost, plans described a Catch-22 in which a plan that is successful at connecting kids to specialty care attracts more enrollees with complicated needs, and plans were concerned about risk adjustment adequately being able to address that issue.

So we had this great discussion, but while we found no magic bullets, participants did have many ideas for solutions. They voiced clear support for care coordinators, whether at the plan level or embedded in a provider location. They suggested an ombudsman in the state division of insurance or state attorney general's office to assist consumers. They proposed education and outreach to really help families understand how to choose insurance products, how to advocate for their needs, and how to file and pursue complaints when necessary.

They supported transitional protections, especially for kids with complicated needs. As one participant stated, if a child has been undergoing treatment with a certain specialist, it's really in the plan's interest as well as a child's interest to allow the child to continue with that specialist.

They also suggested standardizing network adequacy requirements at the state level, so that a single requirement would apply to plans that use a provider network, regardless of the plan type or the payer.

So, in the end, we had a rich discussion, and this panel really gave us a lot to consider, but, as you heard, we didn't really reach an answer to the question of whether changes would be needed to make QHPs work as well for kids as we know CHIP has.

We did gather information on how networks could be designed for kids and different ways that adequacy could be measured. So our contractor, Mathematica, has written a background paper which we anticipate combining with the final summary of this roundtable, and we will present the whole thing as a draft chapter to you in January.

Thanks, and I am happy to answer any questions.

COMMISSIONER CHECKETT: Thank you, Veronica. Interesting. I'm sure it was a great discussion.

I wonder if the group talked about the pros and cons of requiring that QHPs or, I guess, maybe networks in general to contract with specialty children's hospitals, and I ask because if we're going to talk about a pediatric benefit, then one might assume that one should have access to specialty children's hospitals.

As someone who has been on the payer side for my entire career, those are often very, very expensive places to get care, and often -- sitting here next to my colleague here who runs one of those -- and often, frankly not much -- not a lot of flexibility at the table about negotiating on rates, and so it's a real conundrum. And I'm curious for the discussion, and I would hope that this might come up in the paper.

MS. DAHER: Yes. That definitely was discussed at length, and we had some representatives from children's hospitals as well as the providers.

Cost came up and the ability, like you said, the ability of plans to truly negotiate, an acceptable rate came up and also the idea that perhaps certain children with very unique needs might need to be seen at a specialized provider, like a children's hospital, whereas others may be able to seek care in the community for

similar conditions that are less severe. So, yes, we are going to address that in the paper.

COMMISSIONER EDELSTEIN: Given the very high need of these children for dental care, was there a dental representative on the panel, and what did you hear about oral health service adequacy?

MS. DAHER: We did not have a particular dental representative on the panel, but we did have pediatric providers on the panel.

COMMISSIONER EDELSTEIN: I would suggest that that's a very major oversight, given the particular needs of children.

Your bullet here says, "What are the unique needs of children?" and the single greatest unmet need of these children is dental care, so how can we address that?

MS. DAHER: Thank you for that point, and we will make sure to address that in our paper.

COMMISSIONER GABOW: I think one issue that maybe comes up about networks is about transparency, transparency to the beneficiary about what is in network and what isn't in network.

I mean, you can have -- you know the story recently about if you go in an emergency to an out-of-network hospital, you are in trouble, but who plans to go? "Well, I think I am going to have an acute appendicitis in my child, so I'm going to think about which ER is in network."

So I think clearer clarity about what it means to be in network and out of network and transparency about that is important.

I also think it's important that the transparency about how you get included in a network -- I mean, is it on the basis of cost? Is it on the basis of quality? Is it a value proposition? What are the parameters that entities are using to create the network? I think that's more important than having rules

about "adequacy." I don't see how you could do that, but if we have certain parameters that are important, then I think that would be useful.

Sort of, to Donna's point, I think one of the things that happens about this network adequacy is lobbying for being included, without understanding what I just said about what are the criteria for being an in-network provider. Is it that you have very good quality at low cost, or is it that you negotiate the best contractor and did you have the strongest lobby? I think that's important.

As part of that, I really think children's hospitals offer a unique service often to children that aren't available anywhere else. The cost issue does have to come into play, and the addition and the issue of overuse, I think.

We don't have any data -- well, I don't know. Maybe somebody does, but I think having that data would be important as we think about networks for kids.

COMMISSIONER ROSENBAUM: Two questions. One, I don't know. You may have said it, and I just missed it. Did you hold this roundtable before the NAIC Model Provider Network Act came out? You held it when?

MS. DAHER: December 1st, so that was after, I believe, that the draft --

COMMISSIONER ROSENBAUM: Was there any discussion about the model act at all? Did anybody take a look at the model act or comment on the model act?

MS. DAHER: It did come up in the discussion.

COMMISSIONER ROSENBAUM: Yeah. I mean, it's quite an interesting piece of work, been very thorough, and I think it would be a good thing. It's out for comment now, and I think it would be a

good thing to capture any observations about the model.

The other question I had is really sort of a question for Donna or maybe for Herman. When the issue comes up about the cost -- and maybe Patty -- the cost of hospital care for children in children's hospitals, I assume that the concern is the cost of what we should call it. With children, being hospitalized is such a singular event. It's probably not accurate, but sort of the bread-and-butter care. When we get to the subspecialty services or sub-subspecialty services, I can't imagine that other than negotiating for -- to negotiate, that the comparative cost is a big issue because there is no comparison at that point. The issue is the cost of the more standardized services that a hospital might provide to a child.

And I think it would be good, to the extent that there was discussion around this issue, to be clear as to where the cost issue becomes a problem. Every health plan I know -- and again, Richard, you can correct me; Donna, you can correct me -- has a process by which, even if a children's hospital is not in the network, if it's a rare condition or a high-cost -- not high cost. If it's a rare condition that must be seen at a highly specialized hospital, out-of-network coverage is arranged for a special case coverage.

So what we're really talking about here is inclusion of children's hospitals for standard services, and I just think it would be good to be clear on that point because it might begin to lend itself to some solutions.

It's not children's hospitals as a group; it's certain kinds of health care that children need.

EXECUTIVE DIRECTOR SCHWARTZ: And I think there is a lot of discussion in the meeting about, for example, when kids get tubes in their ears versus kids with a life-threatening illness.

COMMISSIONER GRAY: I suppose if you've seen one children's hospital, you've seen one children's hospital. There are certainly 50-or-so children's hospitals that are freestanding, highly

specialized, and depending on the market that they sit in, they can have tremendous influence over negotiating their rates because they are the children's hospital in that community. There are large cities that have one children's hospital or a couple.

Part of the reason for this, of course, is that there are a lot less sick kids than there are sick adults, and the conditions are rare and uncommon, but you have to be prepared to take care of them, of course. If they walk in the door, you can't wait until the child appears and then say, "Well, hang on. We'll find a specialist to provide that care or the services that they need."

But I'm really more interested in the conversation. I think children's hospitals themselves as a group of hospitals are aware of the perception of their cost structures and I think are working at trying to address that, but, again, it's all over the place in terms of the specific hospitals.

But I am really more sort of surprised about the notion -- and it may be just because of what I do and how I might be overly defensive about it, but the notion that a network is okay if the full array of specialists are not available in it because the primary care doctors can do it. And I am speaking as a -- that may be a simplification of what I heard.

I am a general pediatrician and a primary care doctor. Just as families don't plan on having a kid show up with an acute appendicitis in the ED, they don't really plan on having a child with special needs either, and they represent a pretty significant percentage, as I recall, of the population of children in Medicaid and CHIP programs. I think the paper suggests that it's 30 percent or thereabouts in CHIP programs. So this is not an inconsequential number of children.

It partly depends, of course, on how you define special needs kids, as you pointed out, and it could

be everything from being on one medication for asthma to severe cerebral palsy, seeing 10 different specialists. But I'd be very concerned about defining a network as adequate because it had lots of pediatricians in it and community hospitals and no access to really highly specialized care. I don't think we asked that of our -- I'm going to stop in a second. I don't think we asked that of our adults to accept a network that looks like that, and I don't think we should accept it for children either.

The notion of one-offs, having an insurance company make a decision about a particular case, if it's a rare case and the need is perceived to need to send them someplace else, it works really well, conceptually, but if you haven't ever written one of those letters to a medical director, had the face-to-face, had the conversations by telephone, and then have a non-pediatric medical director say, "No, we're still not going to send them," that's an extraordinarily frustrating experience.

Just recently, we had a case in our hospital of a youngster who is being cared for in our children's hospital by our hematology, oncology physicians, and their case was so rare that they believed they needed to be sent to yet another children's hospital. And the physician who was caring for the child in this very rare condition could not convince the plan to send the child to the second children's hospital, would not even get a phone call back from the medical director, just said, "Sorry. Got to be cared for here."

So this one-off kind of approach, I think is a very inefficient one and often doesn't work very well, and care management, I think is a great idea, and the care coordination, so that the child receives the right level of care in the right place. And putting tubes in ears for some children's hospitals certainly is not a good use of that facility, but when you take children away from a children's hospital in terms of what they care for, it doesn't make their cost less expensive. And that's part of the challenge, is that they are

children's hospitals, and so they take care of kids.

But I look forward to more elaboration on this subject in the paper.

COMMISSIONER CARTE: Veronica, I was kind of disappointed to see that in this discussion -- and this is somewhat to Patty's point about that there's not a look at cost and volume, and I recognize that that's the problem that some of these children's needs are so unique, and as Herman said, some of the hospitals are so unique. But it seems like this cries out for an analysis at a national level of like what are the most common conditions and then a regional breakdown of what are the centers or hospitals that can deal with certain conditions the most, whether it's blood cancers, or what are the most common conditions that are treated by these children's specialty hospitals, and who has the highest volume for certain conditions, and who has the most -- the best track record as far as quality, because without knowing that, we can't really start to look at value or what ways we can gain efficiency and help to lower subsidies.

And, Dave, really it seems like that would be a good issue for the AAP or some of the specialty docs to look at.

COMMISSIONER MARTINEZ ROGERS: Thank you for the report, Veronica. I am somewhat awed, though. I have to go along with Burton about not having pediatric dentists on this panel. You know, I'm not sure how the panel was chosen, but one thing I do know is that Latinos, Latino children, and the poor have many dental health care needs. That is one of our major issues, which then causes other issues physically, if not also mentally, because of self-image. This is something that really needs to be addressed, and I'm wondering whether or not there is a way that -- and I don't know the process, but is there a way that you can call pediatric dentists to get their opinions? Because I don't think it's enough for

you just to write it up. I think you need to hear what they have to say.

MS. DAHER: Yes, thank you. So we strove for balance on this panel, but as you've pointed out, it could have maybe included the dental providers. So what we can do is perhaps reach out, like you have suggested, so that when we present the final summary, it will be more inclusive of those perspectives.

COMMISSIONER GABOW: To Sara's point, Sharon's as well, I think the model that Denver Health had with the Children's Hospital in Denver was really a very good model in that being a community health center-based system, we certainly saw -- and Medicaid-based -- a lot of children. And I think within Denver, Children's Hospital is not particularly interested in setting up big primary care systems for kids because that was a role -- we were in the schools, and we were in the communities. And we even ran the special needs program for Denver and could do a lot of that within our community health center.

But we had a great relationship with Children's in the sense that they did two things for us: one, they took kids who had unique needs, pediatric cardiology, pediatric neurology, et cetera, rehab that we couldn't do, and they did it, also by sending their specialists to us so that they sent over their asthma doc to run an asthma clinic at Denver Health. And I think that way everybody benefited, the families, and we had a very smooth program of transitioning kids who had to go back and forth. And I think that model is something we should think about when you think about network adequacy. What is the relationship between the core providers for Medicaid, particularly in CHIP, and the children's hospital in a region that can be done both by having the specialists come to one place or by having this referral network? And I think thinking about that as we think about network adequacy, because while I agree with you these one-off deals are very hard, but if you have relationships -- and regarding the cost of children's hospitals, I will say

this: If I look at the Denver model, if we had to create pediatric cardiology, pediatric neurology, pediatric rehab, if we had to duplicate that at Denver Health and create a call schedule, I mean, you can't have one pediatric cardiologist on call 365 days a year. And there aren't that many of them available anyway.

So as we think about the cost of certain high-cost regional centers, we have to also ask, well, what's the alternative? Is it the alternative that you duplicate all those specialties at every community hospital at a very high cost? So it's not as straightforward as it may seem, but I think regionalizing it and thinking about the quality and the cost-to-value equation makes a lot of sense, and doing this pairing also makes a lot of sense.

COMMISSIONER CHAMBERS: Thanks. It's really good information, and I'm very happy that you had the roundtables to get perspectives from all this wide variety of folks, except for the dental piece, which you've heard from. But, you know, network adequacy seems to be such a hot topic of the day, and for health plans, I think it was -- it really became for Medicaid and CHIP-focused plans, I think it was -- with Medicaid expansion, all the stuff that's coming up now is, you know, were delivery systems ready for the influx of larger numbers of folks? And I think, you know, your point about the network and price, I think when you're on the Medicaid side particularly, issues of, you know, the dollars in the system to have a very wide network. And so I think it's just drawing a lot of attention. And both, I think, in the ACA expansion on the exchange side, there's been issues of, you know, advertised networks versus actual networks, and how do you monitor that, making sure -- I mean, as a health plan, we sign contracts with delegated entities, IPAs that actually contract with physicians, and so we're dependent upon the management of those physician, is to monitor, we monitor them to monitor access. But even physicians, I

mean, there are physicians who say, "I never signed a contract." The physician will tell somebody that, and the administrator will say, "No, we actually did sign a contract with them." But they do say no, and they say, "We can't see you for months." But it's just such a hot topic, and I think it's worthy of seeing it.

I think it's when you look at things like Sara's point about contracting with children's hospitals, when you start as a focus of a Medicaid/CHIP plan, are children such a large percentage of your population, it's like having children's hospitals, at least for us -- for me particularly in California, there was great political pressure to contract with children's hospitals. But then we have these odd programs where special needs kids are actually carved out of the Medicaid delivery system to a separate system that does most of the purchasing of services in children's hospitals. But having those contracts is critical, and I can't say that's the way it is all across the country, but certainly is that -- so I think, you know, you're asking the right questions that you were asking at the end of the presentation, and I think, you know, we need to make sure that you're addressing all of those things going forward. It's the care coordinators being part of the ombudsman program, education and outreach. As we found with the Medicaid expansion population, there's very low utilization, we're actually making outbound calls and saying, geez, do you actually understand the benefits that you have and that there's access to providers and hooking them up to those.

So absolutely education and outreach, transitional protections, and standardized network adequacy, all the right questions to be examining to make sure it's happening. So thanks.

COMMISSIONER RILEY: I just want to make a quick comment. I appreciate very much the concern about oral health. One could raise the issue of behavioral health. But I don't want it to take away from the importance of this roundtable. I think getting -- it's very hard to balance who should be at

the table, and I think you did a good job doing that. And I think the fail-safe is always the consumer, and you had consumer advocates. And I wondered if there were particular areas of network adequacy that they brought up, maybe oral health, maybe behavioral health, that would be different from the rest of the group.

MS. DAHER: I think there was a common understanding of where the gaps are. There seemed to be agreement, especially child psychiatrists came up with the advocates as being one of the aspects that's harder to find. And they were really -- the advocate was really concerned about people's ability to understand the networks before they purchased, and understand what they should be looking for when they go to purchase a plan, and then understanding if they are finding that in a particular plan.

COMMISSIONER WALDREN: So one thing I think would be interesting, especially as it relates to the telemedicine piece of it, is how can we transform the way the care is delivered. So I agree with Herman as a primary care doc, or at least was a primary care doc, you know, there are certain things that I could do that I was trained to do that I didn't do because there are political or issues around there, and we can work on those. But you can't substitute a primary care doc for the specialist.

But what do you need of that specialist? If it's a cognition piece of it, then telemedicine works very well relative to that. If it's a diagnostician, then you need some additional tooling to support that remoteness. But then if it is actually doing the actually procedure, then, of course, you can't do it that way.

So I think as Sharon mentioned, looking at those different types of patients, but also what are those different types of needs based on a specialty care perspective. I think that could also lead into then some of the issues around the children's hospital stuff. There's a project in New Mexico started by a hepatologist called Project ECHO, and he was getting referrals from primary care and others for people to

get liver transplants. And he's, like, "Well, if I would have been involved in this patient's care six months ago or 12 months ago, we probably wouldn't be doing the transplant this year. We may be doing it five years from now."

So he started a project where he has a team of individuals at the tertiary care center that has televisits with the primary care doc and the patient, so you have that entire team. So now you have not only that hepatologist, but you have the nutritionist -- and I think we could think about what are the business models to support some of the capacity needed that's just sitting in these tertiary children's hospitals not being used, but the cost has to be -- I'd say the price. I never say cost. The price of using those is because of that extra capacity just sitting there not being leveraged. So I would hope that we'd start thinking about how could we look at a different transformed delivery model to support the needs and lower the cost.

VICE CHAIR SUNDWALL: Just a quick question. We have the same program in Utah we adopted from them. It's terrific, and it's been proven to be cost-effective.

COMMISSIONER CHECKETT: Well, perhaps wrapping up the discussion here, which I think has been interesting, you know, I just want to go back and clarify that I raised the question about did the group recommend that there be a requirement that pediatric hospitals, specialty hospitals be in network? Because, surprisingly, there are a lot of networks that don't have children's hospitals, and, Richard, not all state Medicaid agencies require it, which I find fascinating because you wind up getting very, very unequal networks that create a lot of other issues within a market. So it's, you know, a question that has a lot of ramifications.

I also do just want to briefly bring to the Commissioners' and the staff's attention as well that in

Kansas City Children's Mercy Hospital, they have a pediatric accountable care network that is doing some extraordinary work where they are actually -- the children's hospital is taking full risk on Medicaid children. And really they're well into their second year. They've got I think close to 100,000 kids involved and have really stepped up to the plate in terms of, you know, this is what a payment partnership looks like to me, is that we are sharing -- as a payer and a provider, we are sharing in care outcomes, we're sharing in goals, we're sharing in financial responsibility. It's a terrific model. I think it will be interesting to see, and I know there are similar things in other parts of the country as well. So worth looking at.

Far beyond your little focus group, we have taken you oh, so far, but we love to do that, and so thank you.

EXECUTIVE DIRECTOR SCHWARTZ: Donna, can I just step in for a clarification?

COMMISSIONER CHECKETT: Sure.

EXECUTIVE DIRECTOR SCHWARTZ: We didn't ask the group to come to a consensus recommendation on anything.

COMMISSIONER CHECKETT: Okay.

EXECUTIVE DIRECTOR SCHWARTZ: We had them for a day, a short day at that, and the purpose of doing these roundtables is we can gather information by having a series of serial conversations with the different stakeholders. But what we found with the roundtable is that you put them in the room together, and you see where they argue a bit or where they reinforce each other, and it's really just to enhance that information gathering. It really was not supposed to come to consensus on anything.

COMMISSIONER CHECKETT: Thank you so much for the clarification.

COMMISSIONER GRAY: Just a little bit of information to sort of help understand this children's hospital world a little bit. You know, over the years I've had to recruit lots of different specialists to our hospital, and sometimes it has been quite challenging to find them. So I started looking at the training numbers and had, you know, other docs and specialties tell me, so pediatric urologists, we graduate somewhere between 30 and 40 of these doctors a year in the entire country. It's not anywhere close to even keeping up with just, you know, death and retirement. There are fewer than that pediatric neurosurgeons. I think the state of Michigan may have six pediatric heart surgeons between the three major children's hospitals in the state.

When we talk about rare and unusual conditions, we're also talking about the people who take care of them. These are folks that are really few and far between and very difficult to find, and typically their training period is longer than that of their adult counterpart. So a pediatric heart surgeon has to go beyond the traditional training of the adult heart surgeon, you know, an additional two or three years for pediatrics, and then have the pleasure of being paid less. You know, it's much more lucrative to do a bypass, put in a stent, you know, in and out in an hour, as opposed to working on a heart that is the size of a plum that is, you know, put together for whatever reason, you know, the universe decided to be completely backwards and twist it, and spend hours in this tiny little surgical field.

So there are lots of reasons -- and then, of course, the vast majority of their patients are covered by Medicaid. And so there are lots of reasons for why, besides just the incidence of the disorders, that make for a very challenging environment to provide care to these very special and important kids.

CHAIR ROWLAND: Well, thank you, and thank you, Veronica, for just giving us a little bit of a

flavor of what you were going to be reporting to us on in January. Aren't you anxious to come back in January?

[Laughter.]

CHAIR ROWLAND: I think this has been very helpful because it has really broadened us to look more at some of the challenges in figuring out what good access is and where we should be going. So thank you very much.

Also, at this point we would welcome any comments from those who have joined us in the audience this morning before we break for lunch. If anyone would like to make a comment, please come to the microphone.

PUBLIC COMMENT

* [No response.]

CHAIR ROWLAND: Well, then, we will adjourn and resume after lunch at 1:30. Thank you.

* [Whereupon, at 12:17 p.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION [1:41 p.m.]

CHAIR ROWLAND: Okay. We will resume our Medicaid and CHIP Payment and Access Commission meeting, and we're going to shift a bit from our morning discussion on CHIP and children to look at the experience and some of the issues related to the premium assistance model and Medicaid's expanding role in the private health insurance market. I could remind you that this is a chapter that we're really getting in preparation for our March report, so please make sure that the content and the framework is something that we are comfortable with.

Martha.

DRAFT MARCH REPORT CHAPTER:

PREMIUM ASSISTANCE: MEDICAID'S EXPANDING ROLE IN THE PRIVATE INSURANCE MARKET

* MS. HEBERLEIN: Thank you. As Diane said, I'm going to spend my time today talking about premium assistance and going over the draft chapter for the March report.

So, premium assistance is the purchase of private plans for Medicaid enrollees, and it has received a lot of attention lately as states are thinking about alternatives to an expansion of traditional Medicaid coverage to the newly eligible population.

So, two of the 28 states that are moving forward, Arkansas and Iowa, are taking this approach through Section 1115 waivers. And, while they differ on some of their design decisions, both are using Medicaid funds to purchase qualified health plans, or QHPs, on the exchange for individuals who are otherwise eligible for Medicaid.

I want to note that there are other states, such as Michigan and Pennsylvania, that have secured waivers to test alternatives to straight Medicaid expansion by altering either their cost sharing or benefit design. But, as they are not purchasing QHPs for Medicaid enrollees, they're not the focus of this chapter or discussion today.

So, the premium assistance approach raises a number of important policy considerations. And, while it will be several years, as you guys, I am sure, understand, before the data are available that can provide a full assessment, raising the questions now can help us think further about what future analysis and evaluation we should be doing.

So, the draft chapter I will present today provides a brief overview of the history of the use of private plans in Medicaid, and then lays out questions surrounding the use of premium assistance for the newly eligible group as well as the possibility of extending it further. As discussed at the September meeting, this chapter places premium assistance in the broader market perspective and focuses on some of the policy and design issues associated with the approved waivers.

Specifically, today, I will discuss some of the differences between the use of managed care in Medicaid and the use of premium assistance to purchase QHPs; the reasons states may choose the premium assistance approach to the Medicaid expansion; the differences between the benefits offered and the cost sharing required in traditional Medicaid and the waivers; the protections for Medicaid enrollees that have not been waived, including the medically frail exemption, retroactive eligibility, and grievance and appeal rights; some of the potential cost considerations for using premium assistance; and, finally, the need for a thorough evaluation.

So, starting with the comparison of the use of private plans in Medicaid, the private plans have long been purchased for Medicaid enrollees, although more often through the use of managed care than premium assistance. And, while both rely on private plans to deliver services to enrollees, there are several important differences in terms of state oversight and management functions as well as the method of determining payments that I want to spend a little bit of time on here.

So, starting with managed care, the majority of Medicaid enrollees receive their benefits through private managed care plans. States have pursued the use of managed care for a number of reasons, including better care coordination and improved program accountability for access and quality. Additionally, by paying MCOs a set capitated rate, states can capitalize on more predictable budgetary expenditures. In an MCO arrangement, state contractors establish the terms under which the plan will deliver services, for example, by stipulating certain network standards. Additionally, in order to monitor whether the plans are meeting the contract requirements, states can establish data collection and reporting requirements as well as sanctions and other enforcement mechanisms. And, while Medicaid programs use a variety of methods to set capitation rates for their managed care plans, the rate is based on the estimated cost of serving a specific population in Medicaid.

In contrast, in the premium assistance approach, states buy coverage through a separate system that was done for a non-Medicaid population. Despite having been permissible since the beginning of Medicaid, the direct purchase of private plans through premium assistance has been relatively limited, enrolling very few people and concentrated on employer-based coverage. The low enrollment is likely due to several factors, including a limited number of Medicaid eligible persons having access to comprehensive

employer-based coverage, and prior to the ACA, the difficulty many people had in qualifying for individual market coverage.

So, in both traditional employer-focused premium assistance and the QHP premium assistance demonstrations, states do not directly contract with insurers, and instead, employers, state insurance departments, and exchanges have roles in establishing the insurance standards which may or may not match up with state Medicaid rules. Additionally, Medicaid programs that purchase QHPs may not have access to the same level of information on service use, provider payment, or coverage and utilization management policies. And, finally, the premiums for QHPs and other private market plans are determined using rating rules that apply to the whole market.

So, why states might choose premium assistance. Press accounts have often focused primarily on the premium assistance appeal to voters and legislatures in politically conservative states. However, there are at least two other compelling rationales that are driving the adoption of premium assistance: Reducing churning between plans and improving access to providers.

So, due to changes in income and other family circumstances, almost seven million people are estimated to move from Medicaid coverage to exchange coverage or vice-versa from one year to the next. This churning increases administrative costs and disrupts continuity of care. So, premium assistance has the potential to lessen the impact of churn if the plans offered to the premium assistance population are the same as those offered to consumers using premium tax credits to purchase qualified health plans. Additionally, if coordination between the programs is well established, the transfer between them could be seamless for individuals and potentially eliminating gaps in coverage. As of yet, there are no available data

to assess the extent of churning and whether premium assistance is mitigating any disruptions in continuity of care.

Another argument often made in support of premium assistance is that it will improve Medicaid enrollees' access to care. Through the use of premium assistance, the assumption is that the purchase of a commercial product by definition is providing the equal access required under the statute. States have also suggested that by paying higher commercial or commercial-like rates to providers, access will improve as a result. Currently, just one-third of the physicians are accepting new Medicaid patients, with payment rates that are typically below commercial rates cited as the reason why. When enrolling in a QHP that pays higher rates, a Medicaid beneficiary could potentially have more options for providers if there is a wide range of plans with a robust network to choose from. However, there is little evidence yet to evaluate the extent to which premium assistance impacts access, as there have been reports of network and access limitations in both programs.

So, certain federal Medicaid benefit and cost sharing requirements are not mandated in QHPs and are waived in the Arkansas and Iowa premium assistance expansion. Thus, these waivers differ from traditional Medicaid in several key ways.

So, starting with the benefits, Medicaid enrollees who come in through the new adult eligibility pathway are required to receive the alternative benefit package, or ABP. The ABP must cover certain services, such as EPSDT for children under age 21. In contrast, QHPs are only required to offer the ten essential health benefits. States adopting the premium assistance approach will either need to cover any missing benefits or secure a waiver of benefit requirements from CMS.

Under the current waivers, both Iowa and Arkansas are required to wrap EPSDT benefits. That means that the state will provide those services that are unavailable through the QHPs through their fee-for-service programs. Enrollees will receive both a QHP card and a Medicaid identification number that allows them to secure their services. And, information on how to receive those wrapped benefits as well as which benefits are wrapped will be provided through the eligibility notice.

On the other hand, Iowa has secured a temporary one-year waiver of non-emergency medical transportation, or NEMT, and has submitted a request to continue that waiver into year two. Arkansas has also submitted a waiver seeking to waive NEMT, but is currently providing the benefit through their fee-for-service program like they do for EPSDT.

Medicaid's prior experience with premium assistance has yielded little information as to whether individuals have been able to access the benefits to which they are entitled and the administrative process that this entails. So, going forward, examination of the benefits as well as what has been waived will be important.

In terms of cost sharing, states adopting the premium assistance approach to the expansion are also considering waivers of Medicaid cost sharing requirements so that all enrollees pay something, even if it's nominal, towards the cost of coverage. This notion of personal responsibility in the form of a financial contribution resonates deeply with some policy makers, making coverage of expansion more palatable.

In Iowa, enrollees with income between 100 and 138 percent will pay $10 premiums, but premiums will be waived in the first year of the demonstration and waived in subsequent years if enrollees self-attest to a financial hardship or complete healthy behaviors, such as a health risk assessment or an annual wellness

exam.

States are also testing different approaches to cost sharing that mimic private sector practices, such as requiring enrollees to contribute a certain amount towards a Health Savings Account that can be later used for service charges. Arkansas has submitted an amendment to its existing waiver requesting the use of an HSA for those enrolled in a QHP. While it has not yet been approved, the state is seeking to charge monthly contributions, ranging from $5 for enrollees with income above 50 percent to $25 for those at 133 percent.

Despite these changes, enrollees' exposure to out-of-pocket spending remains restricted in both states by limiting the use of cost sharing and maintaining the five percent of income cap. There is still potential risk to these provisions, however, as increasing cost sharing can discourage people from seeking coverage and needed care, and the financial incentives for healthy behaviors has shown mixed results in past use.

So, as mentioned at the beginning, there are a number of protections that were not waived in the Arkansas and Iowa waivers. First is the exemption for medically frail. So, states adopting premium assistance must identify medically frail individuals who are exempt from enrollment and premium assistance and give them the option of enrolling in the full Medicaid plan.

States have discretion in determining how these individuals will be identified. In Iowa, there are three ways in which the enrollee can become medically exempt. They can either through a medical member survey, a provider attestation or referral, or through a retrospective claims analysis. In Arkansas, applicants will seek a determination of medical frailty or identified through a screening questionnaire.

However, there are some concerns as to whether self-identification is a viable approach to identifying the medically frail, as self-reports of health status may be unreliable.

Retroactive coverage -- so, Medicaid must extend three months retroactively if an individual would have been eligible during that time, and this requirement remains in force in the premium assistance programs. It may save beneficiaries from out-of-pocket costs by allowing medical care received prior to application to be covered by Medicaid. And, this is a benefit to providers who saw them, as well.

In both Arkansas and Iowa, enrollees will be able to access benefits through Medicaid until the QHP enrollment is finalized.

As for appeal rights, Medicaid applicants and beneficiaries have a right to adequate notice and the opportunity to challenge an adverse state action. QHPs, like all individual and group plans, are required to have an internal claims process as well as to give access to an external review process. While eligibility appeals across programs are required to be coordinated, there is no such requirement for denial of benefit or claims appeals.

Medicaid agencies also may delegate certain appeal responsibilities to the Department of Insurance or another agency, and so while enrollees' appeal rights are maintained, it's unclear at this point as to whom those appeals should be directed, how they will be coordinated and if they will be, and who bears ultimate responsibility for their adjudication.

So, moving on to costs, the key question about the premium assistance models that's on lots of people's minds are their costs compared to that of the traditional Medicaid. Federal policy requires that Section 1115 waivers are budget neutral, meaning that federal spending under the demonstration is equal to

or less than what it would have been in the state without the demonstration. Whether or not that proves to be the case will be a function of several factors, including the population that enrolls and the cost of the marketplace. Using premium assistance to purchase private plans which historically have been more expensive than Medicaid would likely be more costly. However, providing Medicaid enrollees a private market plan through a QHP might be cost effective if other things are considered.

In Arkansas, an additional 200,000 people who have been covered in the Medicaid program are covered through QHPs. This has substantially increased the enrollment in the marketplace, and this could have the potential to lead to a healthier risk pool as well as increase the number of insurers who are looking to participate in the marketplace. So, these two factors together may drive down premiums. But, the potential impact that we've heard about in Arkansas may not be seen in other states, in part because of the size and the health status of the expansion group as compared to those enrolling in the exchange directly.

So, moving on to evaluation. To date, premium assistance hasn't been tried on such a scale and is certainly worthy of the evaluation that's required under the statute and regulations. Important questions that should be answered -- or asked, at least -- in any evaluation of the premium assistance include the extent to whether more people are covered as a result; whether it affects enrollees' access to care; whether benefits are provided through a wrap to those who need them and the impact of waiving benefits; the effective premiums, cost sharing, and incentives for healthy behaviors on enrollment and service utilization; whether QHP enrollment eases the transition and improves continuity of coverage and care as enrollee income and family circumstances change; the accuracy of the medically frail screening in identifying those individuals who are exempt; and the larger effect on the marketplace as a result of purchasing QHPs for the

Medicaid population.

The state evaluations will look at whether or not the waiver was cost effective in a manner that takes into account both the initial and the longer-term costs, such as health outcomes. And, there are also more specific research questions that the evaluations are designed to answer, for example, whether premium assistance beneficiaries have equal access, or equal or better access to care, fewer gaps in coverage, continuity of provider access, and satisfaction with services. Additionally, the evaluations will examine whether enrollees are able to access the benefits through the wrap and the impact of waiving NEMT on access.

So, updates on enrollment and implementation will occur earlier in the evaluation process with outcome data coming much later, and final reports will not be due until the end of 2017.

Additionally, there is a national evaluation that has just gotten underway. It will look more broadly at Section 1115 waivers, but will look specifically at these premium assistance. We are looking in more to what this will detail, but results will probably not be available on the national level until 2019.

And, not that I need to tell you this, but as with all evaluations, there will certainly be limitations to the generalization of those results.

So, the purchase of QHPs for Medicaid enrollees is a new thing and just coverage has been available since January in just two states. So, little data are currently available on the relative impact. But, because this is such a new idea and because there has been interest in other states, there is widespread interest among both research and the policy community to have a better understanding of what this means for states as well as beneficiaries. So, while data may currently be limited, it is expected that more research will be

available given this broad interest.

So, a complete assessment of the questions raised here also have implications beyond the premium assistance approaches in Arkansas and Iowa. So, of the 23 states that have not expanded Medicaid, some may seek alternative approaches. In fact, Utah released its plan just last week and they have proposed purchasing QHPs for Medicaid enrollees.

The premium assistance is also relevant beyond the new adult group. For example, there have been discussions here and other places about the use of exchanges for children who are now covered through CHIP. So, the experience with the Medicaid eligible adults in these premium assistance models can certainly help inform the viability of the approach for children.

Finally, beginning in 2017, states may seek innovation waivers to help develop alternative approaches to meeting the ACA coverage goals, and premium assistance could play a role in these so-called super-waivers.

So, with that, we will continue to watch what's going on in Arkansas and Iowa and I look forward to your comments on the chapter.

COMMISSIONER ROSENBAUM: Sorry.

So I, first of all, want to commend you for the chapter. I think it's very good. I think it's very well balanced. It identifies what to me is a very important direction for the program and one whose overall performance and impact will take years to unfold, but that's the nature of Medicaid. So when we try new things, we learn over time.

I think it is interesting to think about where we are with Medicaid in the larger context of health

reform. It is absolutely true, of course, that Medicaid has always been able to buy insurance. It really didn't, because most beneficiaries had no connection to employment insurance, and there was simply no other market to buy. I mean, there was no individual market. Even though Medicaid had the flexibility, there was really nothing to exercise the flexibility in relation to.

Although I will note that, in fact, Medicaid has been buying insurance for 50 years, namely Medicare. I mean, it has been buying insurance, and most people don't think of Medicaid doing that, but in fact, it's been a one-off program. It buys Medicare coverage, and Medicare coverage is something that happens relatively outside of Medicaid's control. And there are places where the two systems interact, but it, in fact, is a huge buyer of what we consider insurance.

I think you are right to identify the issues you have identified as the ones to watch, and I would add one or two. First of all, I think Arkansas is a very interesting example of where you would launch premium assistance, precisely because it was a state that didn't have a well-developed Medicaid managed care market. So it wasn't like it could turn to its existing managed care organizations. They would have, essentially, had to build a Medicaid managed care market from scratch, and under the circumstances, I think it made eminent sense because of the relationship between Medicaid and premium subsidies to look first to the market that was developing, anyway. I mean, it's a small state and a poor state, and there are only so many markets you can develop at the same time.

And I do think that one of the most important features of this is actually the medically frail adult feature, because to me, it makes sure that Medicaid continues to do what only Medicaid can do. Very interesting, in some ways, Medicaid as part of a premium assistance program, I think begins to give

policymakers a real appreciation of what Medicaid can do that is quite separate and apart from what a standard market can do.

So to the extent that Medicaid succeeds in allowing relatively healthy people to come into a risk pool and to help establish that risk pool and make it stronger, which in a poor state like Arkansas is incredibly important, that's great. At the same time, Arkansas has, under CMS standards, made sure that people who need Medicaid, to function in ways that we know Medicaid functions, continue to have access to it.

So I think understanding how the medically frail adult program works, it's going to be one of the most important things going forward.

CHAIR ROWLAND: Sara, can I interrupt you?

COMMISSIONER ROSENBAUM: Yeah.

CHAIR ROWLAND: I think that one of the other important things is that the medically frail are going to be more expensive --

COMMISSIONER ROSENBAUM: Yes.

CHAIR ROWLAND: -- than the people that go into the private market, and it's very important, as we look at the relative costs, that we not just say, "Oh, those that ended up in Medicaid" --

COMMISSIONER ROSENBAUM: Exactly.

CHAIR ROWLAND: -- "cost a whole lot more in Medicaid."

COMMISSIONER ROSENBAUM: No. To understand what you're doing.

CHAIR ROWLAND: So it's the cost and the quality side that we want.

COMMISSIONER ROSENBAUM: That's right.

And the related issue, of course, is when we evaluate cost, what the Medicaid premium assistance model does, I think, is gets squarely in front of policymakers, the question about how do we think about what Medicaid costs, period, because if you pay a somewhat higher premium, so-called "premium," to enroll people in the exchange plans, but overall, in fact, the federal premium subsidies stay relatively stable or don't rise as quickly, this is potentially a very important use of Medicaid. And so cost impact analyses have to reach beyond the Medicaid program.

I think it's something we have all known for years about 1115 demonstrations, and I think this really sort of puts the issue on the table. And that includes the countervailing costs of keeping people who are not in as good health in a more traditional Medicaid program that can better function to meet their needs.

I think another really important set of issues here is the question of what benefits do we need to supplement a standard plan. Now, the law, of course, provides in Medicaid, when you offer what's being called "alternative benefit plans," that you have to supplement with non-emergency medical transportation and EPSDT benefits. And so, essentially, what CMS is saying is we're going to follow that protocol if you buy qualified health plans as well.

And I think understanding what gets used as a supplement, how the supplement works, what possible models are for making supplementation work is a really important issue in all of this. Certainly, the cost-sharing and premium questions that are going to come up in the Iowa model are very important.

And I want to be sure that we talk about this other issue that has been surfaced. We surface it in our chapter. It's come up before, which is this issue of accountability. Do Medicaid programs lose their ability to make sure that plans are accountable to them?

I frankly don't understand. I mean, I don't understand these. I understand that the purchasing that is going on here is different from purchasing Medicaid managed care. It's a different legal relationship, but there is no reason why a department of insurance cannot make sure that for its biggest single institutional purchaser in the exchange, that any licensed insurer doing business with the Medicaid program enters into a series of agreements about how the Medicaid agency will relate to the plans.

I also think -- and this is where I would be really interested in Richard's and Donna's views. I spent a fair amount of time thinking about companies that are doing business in both markets, and I assume that one of the things that this will hurry along, which I think is a very good thing, is the development of more and more plans that are, for want of a better word, hybrids. In other words, they satisfy the requirements of multiple markets. They have a network that we need to understand better. Whether it's going to be the identical network in both markets, I don't know. I think that is a really important -- that is, in some ways, the most important issue because that's where the churn issue really -- a multimarket plan could make a big difference.

But the experience of essentially working with a department of insurance and a Medicaid program to grow products, that on the issues you raised as well as other issues, as well as the ability to deliver some supplemental benefits, can satisfy the requirements of a Medicaid purchaser and a department of insurance, I realize that in the first year or two of implementation of health reform, everybody has been so overwhelmed in getting the new market off the ground, that the time spent on knitting markets together hasn't happened yet.

But when we did for Commonwealth, a multimarket study, interviewing people who are dealing with

developing multimarket plans, what we found was that, in fact, companies were not having a hard time, that it was a relatively straightforward thing to do, and there ought to be an expectation that when you are putting these two markets together, the two markets will begin to speak with each other, interact with each other. Medicaid agencies and departments of insurance will work together.

In a lot of states now, to sell Medicaid managed care, you have got to have licensed -- you've got to hold an insurance license.

So I think that relationship, how that relationship grows is something that we want to be sure is captured in any evaluation that's done.

I have heard Andy Allison a couple of times on this issue, and I know he feels that he was able during his time there to sort of develop a working relationship. This is something that I think goes right to the heart of state flexibility, and it's something over which states have a lot of control under the law to make happen. And we can learn a lot from these early efforts about how these agencies come together.

I consider this an incredibly promising development in Medicaid's long evolution and something that's been sort of hidden in the statute all along that is now for very good reasons, because, suddenly, there's the possibility of continuous care. It's a step that we can take, and it should be explored.

COMMISSIONER RILEY: I am very much on the same page with Sara, but I think we need to step back or up a little bit and think about when you talk about political appeal, I think it's far more than that. We ought to explore it a bit more, and those 23 states that are not expanding Medicaid, it's less of politics in some ways than it is about philosophy, that these are states that profoundly believe that Medicaid is for vulnerable people, and that people who are between 100 and 138 percent of poverty who are

connected to the workforce and who are healthy may, in fact, better be served in a subsidy program in an exchange. And it's a really very important, sort of nuanced approach to how they think, I think, about what the issues are here.

And the court's decision gave the states the ability to make the determination about what is Medicaid. It took it away from the federal government when the federal government said, "Everybody under 138 percent isn't Medicaid-eligible." The states get to decide that. So I think we really have to focus in on what it really means for those 23 states and then talk a bit about -- in fact, I suspect many legislators in those states and maybe even some of the governors believe that what these two states have done is buy private insurance. That is not the case. It's a different twist on hybrid.

They have bought private insurance with a requirement for a complicated hybrid of wraparounds. So, arguably, maybe they should be allowed to just buy straight Medicaid and for those people that are not medically -- straight private insurance for those people who are not medically fragile, but that is not the case.

So I think we really do need to study a little bit more about what this wrap-around is, how many people use it, are these people, in fact, healthy, able-bodied folks, or do they really look more like Medicaid people, and then what's the administrative complexity that buying private insurance with the wrap requirements and the insurance regulatory requirements add to what ought to be a simpler solution, arguably, in the minds of those states that are advancing it.

But I would agree that I think it's a promising approach, but we have almost burdened it. What is it? It is premium assistance for a private product plus, plus, plus, plus, plus, and it's the plus, plus, plus, plus, plus, I want us to look at and try to figure out is that value added, is it essential, what does it cost, what

are the administrative requirements.

[Bell sounds.]

COMMISSIONER RILEY: My time must be up.

[laughter.]

VICE CHAIR SUNDWALL: Okay. I am going to follow up kind of on Trish, and thank you. This is very enlightening for me.

I can't overestimate the importance of your point about political appeal. Coming from a conservative state that has been wrestling with this expansion for now several years, this is the only way we would do Medicaid expansion because of this philosophy that Trish is alluding to.

It is really important, we also got hung up with the personal responsibility requirement in our waiver. It was considered too stringent, some work requirement, and so it was delayed. But it's my understanding that the Governor has received approval. Whether or not it's in writing yet, I don't know, but we now have to go to the legislature, and it's still up for grabs. I don't know if we'll go forward with this, but, anyhow, it has great appeal along with personal responsibility.

I just have one quick question for Sara. When you say -- and I appreciate your historical perspective that Medicaid has been buying Medicare policies, but, in fact, I think you mean Parts B and D or C, not A.

COMMISSIONER ROSENBAUM: Yeah. No, I mean -- well, for those people who don't have an earnings history under Medicare, under Social Security, Medicaid can pay Part A as well.

VICE CHAIR SUNDWALL: Oh, okay. So if they were entitled to that --

COMMISSIONER ROSENBAUM: Yeah.

VICE CHAIR SUNDWALL: -- because they weren't entitled to Social Security?

COMMISSIONER ROSENBAUM: Yeah. I mean, there are -- it's, of course, an increasingly shrinking group of people, but there are people for whom Medicaid will buy traditional Medicare or Medicare Advantage, obviously.

VICE CHAIR SUNDWALL: Well, a lot of us have great faith in this policy, but I think, a Trish has said, we need to evaluate it over time and see if it works as well as we hope it will. But it does give people like me some hope that there is a mechanism to get more people covered that's politically acceptable.

COMMISSIONER GABOW: Thank you. This is complicated, and I think I would agree, it's nicely done. I have four comments.

The first comment is, one of the reasons for doing it is to say, "Well, we'll be paying providers more, and so we'll have more providers entering in the care of Medicaid patients." I would point out the obvious that states could pay Medicaid providers more. Period. So that you don't have to create a new system in order to raise the payment, and I think we should be clear about there's a direct way to achieve that.

The second comment, I think relates to sort of both what Sara and Trish sort of said, and that is this concept of Medicaid is a wraparound to private insurance in a broad way. So, in that regard, I have sort of two questions. What information we do have about the disabled children for whom Medicaid is a wraparound for commercial -- I mean that exists? And what do we know about how well that wrap works and what it is?

Having the medically frail excluded could be thought or about it as a wraparound, in essence. So

these are people who will never be included in routine private insurance.

So I think that putting those in the same bundle, I think has utility in thinking of the future for Medicaid. Is Medicaid of the future really a wraparound for commercial insurance, both for everybody who needs supplemental things and then for the medically frail? So I think that's worth thinking about in that way, perhaps.

The next comment I would make is, as things are being excluded in these waivers, transportation, I think is one that deserves special comment, because if you look at why providers don't want to take Medicaid patients, payment may be one. Complexity of the patients may be another. The complexity of the administration may be one. But an important one is the no-show rate for this population. Providers hate to have their office not maximally used, and when you take out transportation, I think one of the things that we need to monitor, which we didn't say directly that I think we should, is what does it do to the no-show rate. My suspicion from having had this be a big issue is that it will increase, which will make problems for providers, I think.

And the last thing I want to say is a question. When people are doing budget neutrality, are they adding the wraparound and the medically frail into that bin, which is sort of -- well, I think Sara was also alluded to. I mean, what is in the neutrality issue, as well as what it does to the overall commercial premium? So how that's built, I think is worth really thinking through too.

Thank you.

CHAIR ROWLAND: You know, to pick up on Patty's point about transportation, if transportation is not included and the individuals need to pay out of pocket to take a bus or a cab on their

own, then their financial burden associated with getting medical care increases, and if you layer on top of that, copayments, you can really tip the scale there. And that's probably worth noting as well.

Norma.

COMMISSIONER MARTINEZ ROGERS: Especially the rural areas, as Burt just told me, but even if in some rural towns in Texas, there's no public transportation. So that's going to be a major problem.

CHAIR ROWLAND: Well, thank you very much -- oh, did you have a comment, Mark? Okay. Thank you, Martha. That has been very helpful, and I think the chapter is really shaping up to be an important contribution, and now you've got a little more to add into it. Thank you.

And just as Patty said, there are always options to pay more in Medicaid or to change the way Medicaid pays, and so Moira and Jim are going to review with us again the framework for evaluating Medicaid payment policy that we have bee developing and that will hopefully be included as one of the foundational chapters in our next report to Congress.

DRAFT MARCH REPORT CHAPTER

A FRAMEWORK FOR EVALUATING MEDICAID PAYMENT POLICY

* MR. TEISL: Thank you very much. I did want to point out right off the bat that a lot of this material is very similar to what we presented last month when we were talking about our thoughts around a framework. We took your feedback, and we attempted to incorporate it into what, as Diane mentioned, we think could be a chapter in our upcoming March report. So this session is intended to allow you to provide specific feedback on that draft as we've sort of taken the next step with the material.

So, again, MACPAC's statutory authorizing language does direct the Commission to review Medicaid and CHIP payment policies. This includes, of course, the relationship of payment to access and quality of care for Medicaid and CHIP enrollees. And in our very first report to the Congress in March 2011, we described the payment principles in the statute; we proposed a number of areas for research around Medicaid payment policy; and we raised these two main policy questions, namely: What really is the relationship of payment to access and quality in the Medicaid program in particular? And which payment innovations seem to best address efficiency and economy while promoting access to high-quality services, high-quality necessary services, and appropriate utilization?

We also noted in 2011 that there were rather limited sources of systematic and comprehensive Medicaid payment information available which, of course, creates major challenges for our ability to conduct Medicaid payment analyses. Since that time, we have engaged in a variety of projects to help start to fill in these knowledge gaps that create challenges for our ability to do these analyses. You're familiar with them. They include our MACStats section in each report, the payment policy landscapes we've been doing to try to document the state-specific features of payment for different types of providers. We held a roundtable to better understand the issues related to managed care rate setting. We obviously did significant work to understand the role of supplemental payments and non-federal financing for state payment policy.

More recently, in response to our new statutory requirement to do an annual report on Medicaid DSH, we've been pulling together the different sources of information that we hope will help us conduct those analyses.

1902(a)(30)(A) of the Social Security Act, as you know, is the foundational statutory provision governing payment for Medicaid-covered services, and it identifies five aims, five fundamental aims for Medicaid payment policy: To assure that payments promote efficiency, quality, and economy; to avoid paying for unnecessary care, and the equal access provision to promote access within geographic areas equal to that available to the general population.

Obviously, given Medicaid's role and the combined role of Medicaid and CHIP as major payers for health care services, federal and state policymakers really want to maximize the efficiency of spending in the programs. We know payment policy can be a powerful lever for purchasers to contain costs, but also potentially to simultaneously improve outcomes and indicators of access and quality.

You know there is little federal regulation addressing these Medicaid payment principles. States have and have always had significant flexibility in the development of their payment policies to achieve these aims.

We see everywhere state Medicaid programs increasingly adopting more sophisticated purchasing strategies, though we note that most Medicaid spending continues to incentivize volume and not value, and we also note that that's not limited to the Medicaid program. That's true in the wider health care system.

We also note in the chapter that CMS has proposed a regulation to require a process for considering the effects of payment change on access, though at this point the regulation has not been finalized. We've also noted that at times courts have been asked to weigh in on whether payment policies are compliant with the statute, and recently the Supreme Court has been asked again to weigh in on whether providers and other individuals even have the right to bring suit against states regarding Medicaid payment adequacy.

So here is a graphic representation of how we see the Medicaid payment framework. We talked last month about sort of the details within each of these individual principles, the potential metrics, the data sources, and the limitations, so I'm not going to go through all that again. But we hope that this sort of shows the interrelationship of those different principles and how they all ultimately need to be considered when considering whether payment policy is, in fact, efficient.

So why a framework? Well, we think a framework would allow us and others to evaluate and compare payments in a more consistent manner even if the underlying payment amounts and methodologies are not necessarily the same. It would help us consider whether a particular methodology is consistent with the fundamental aims of payment policy or if it appears to be more or less likely to promote the aims when compared against alternatives.

We also think it could allow policymakers to weigh the effect of payment policies beyond just talking about bottom-line spending, but, again, on these fundamental aims that are articulated in the statute.

Ultimately, we think Medicaid payments should provide access to the right amount of high-quality care at the right time in the right setting, while at the same time attempting to control overall cost.

We hope the framework will allow us to, as much as possible, think systematically about Medicaid payment policy, and, again, this requires measures of all these different statutory principles to be considered sort of in conjunction with one another when talking about efficiency.

We think the assessment needs to use qualitative and quantitative evidence. Obviously quantitative evidence is ideal when available, but qualitative methods can also help us to assess policies when the data don't support quantitative analyses, and this is often true especially for emerging models that we talk about

often here.

We do recognize, of course, that the requirements of (a)(30)(A) are not the only goals that policymakers need to consider when they're thinking about Medicaid payment policy overall. We list several here. Administrative simplicity obviously is a big factor, and policymakers think about that not only for providers but for the states themselves that need to implement the methodologies. Program integrity is a constant concern.

I'll skip down to the last one. Obviously we've talked about this before. The preservation of state approaches to non-federal financing is always something that states think about as well.

And I'd close by noting on this slide that a big issue is policy decisions do often involve tradeoffs. Budget makers don't have the luxury of thinking about Medicaid in isolation. They sort of have to think about it in the context of their budgets overall.

We know that Medicaid programs make many types of payments. They make payments in a whole bunch of different ways, and this ranges from sort of the classic fee-for-service payments all the way to full capitation.

I want to emphasize that we're not just thinking about the application of this framework to historical payment approaches. We really do think that the same principles can apply to emerging models, which we're following closely. I'd even point out actually that the questions posed in the previous session on these premium assistance models were strikingly similar to the ones that we're talking about here.

There has always been variation in Medicaid payment, but these emerging models are sort of expanding the range of variation that we need to think about. We think it makes it even more important

that we try to develop a systematic approach to doing so.

So in that regard, we continue to update and add to our payment policy research in order to inform the application of the framework. We continue to examine payment methodologies, and this, again, includes emerging models. Some projects that we've been working on include more work to go out and actually learn from the states and the stakeholders within the states on their approaches to what are termed "value-based purchasing." One in particular that we've been focused on is the ability of safety net providers, for example, to organize into Medicaid ACOs. And as we heard earlier, these have in some cases included children's hospitals.

We continue to work on the payment landscapes, expand those to different types of providers. We are working very hard to attempt to be able to examine inpatient hospital payment across states while accounting for all the things that make those things different. It's not easy.

[Laughter.]

MR. TEISL: We have a project to look at the 1115 waivers which feature delivery system reform incentive payments, which have been a big topic lately. So we're out in the states, and we're learning more about these things, and as these projects begin to bear results, we think this framework is a nice way for us to sort of bring information back and talk about them in sort of a common way.

So, in closing, while we've made strides in filling the gaps in Medicaid payment policy since we first raised the topic in 2010, there is still a lot that we don't know about the methods and the amounts and particularly about the outcomes or the results of these different approaches. So once again we believe it's helpful to have an approach to systematically think through them.

With that, I thank you and look forward to your feedback on the draft. We have started to get some written comments in, which we're already starting to incorporate.

CHAIR ROWLAND: Okay. Thank you.

COMMISSIONER CHAMBERS: Thank you both. It was very interesting reading, and we've been through this several times, and I know we've put you through the wringer, so we appreciate your evolution here in thinking.

On the policy goals, I'm going to channel Patty a bit here, even though she's in the room, about the administrative simplicity. I'm so happy to see that was number one since we seem to make everything so difficult. I'm curious, on the preservation of state approach to non-federal financing, can you explain that a little bit more?

MR. TEISL: Okay.

COMMISSIONER CHAMBERS: I'm sorry to put you on the spot here.

MR. TEISL: That's okay. Yeah, it goes back to some of the work that we did before around supplemental payments and the different ways that states work with their local government providers and their provider community to help provide some of the non-federal share of those payments. States, understandably, need to think about sort of where the non-federal share comes from when they're thinking about their policy for distributing payments to their providers.

* MS. FORBES: And the other classic example is states that would be interested in implementing a capitated program sometimes haven't been able to do so because they lose the flexibility to offer supplemental payments in the cap rate. And so the federal financing is -- I'm sorry, not federal financing.

It's a payments issue. But, again, the way that the flow of funds works and some of the federal rules around that is driving these decisions as much as these other factors here.

COMMISSIONER CHAMBERS: I feel schizophrenic at times because when I put my old CMS hat on, you know, the heartburn that a lot of state approaches to the non-federal financing piece of it, whether it qualifies as good public policy as opposed to saving state dollars. But then, on the other hand, seeing at the delivery level how important these programs are to continued financing of the programs, but I think there's a middle ground somewhere there where we preserve flexibility but at the same time making sure those dollars are being used most appropriately for meeting the goals that we have, the five principles, access and quality, and so I think we want to make sure that that does.

A couple other comments. I really appreciated the discussion about using qualitative data instead of quantitative data, and there's so many moving parts so quickly right now. I look at some stuff that is going on in California's 1115 waiver. The state has to submit the renewal next year, and they're doing a lot of work in setting up stakeholder work groups, the different elements of what to put in the next waiver. And one of the major focuses has been on provider and health plan incentives, and a lot of discussion has been going on of innovative approaches states have done on using ACOs, on reforming delivery systems, and incentives for, you know, improving quality, improving access, efficiency, economy, all the principles that we talk about.

I just think there's going to be so many innovations that either me as a payer of creating those same incentives downstream, states in setting those incentives to -- like health plans in my case, is to be able to look at them and seeing where these system reforms are going on that are embracing the principles that we

have. And it just may be if we wait for quantitative data, it may be like years of trying to figure that out, but at least promoting that and seeing where things are working and achieving the goals that we have on access and payment. So I appreciate that part of the report and look forward to that in the future.

COMMISSIONER GABOW: Thanks. We all love when you do payment. They're always so easy. I seem to be on a roll for having four questions, so I have four questions/comments.

The first is about the framework. I think it -- I'm not an artist, but that doesn't prevent me from engaging. But I do think it might be interesting in the framework. I drew a picture for you that you can have. In addition to the core statutory pieces, these other pieces could feed into that framework as well. For example, simplicity can feed into efficiency. So I think these other factors that are important should be in the visual, I think.

A second question is: Does the varying FMAP and low and high DSH states affect the payment principles in some way? Does that deserve mention in the context of this paper in some way? I don't know the answer to that, but it seems like it should matter.

The third one is: Could you say something about why don't the all-payer databases that are coming up in the states -- how could that contribute to our understanding of this terrain?

And my final comment is that I actually think this chapter could have two recommendations. One would be that we should have transparency of all payment data, specific hospital DSH payments, managed care payment rates, et cetera, and that we or others in government cannot do their job or understand the value that's coming out if there is opaqueness to this data, and that transparency is important.

And the second potential recommendation would be that CMS actually issue the final rule on access.

It appears to have been incubated for a substantial period of time, and when should it be hatched I guess is a question. Or maybe it should never be. Maybe there was enough public comment that it made it not worth going forward and they have assessed that. But either yes or no, I guess, either they're going to do it, or they're not going to do it. And having some clarity on that I think would have utility for all the people who have to deal with this.

Thank you.

COMMISSIONER MOORE: Well, I you have one question, although it may not be very clear, so I'll meander a little bit.

First of all, I think it's a good paper and a good framework, and I just always am very pleased when we start talking about payment policy and supplemental payments and the wonderful world of that complexity, because it's certainly been in recent years that people have tried to look at that sort of thing.

My concern and my question is the extent to which the delivery system reform payment demos or experiments, whatever we are calling them, the extent to which they will answer more questions than they raise or provide insights that we don't now have and how long that might take. Or it's sort of where all that is, and I think the Commission, as the year and the next couple years go by, needs to have a better fix on that.

MR. TEISL: I mean, I'll only say that the project to examine those programs in particular is ongoing. I think the site visits are completed. So we've finished that step and now need to do the work of sort of bringing together what we've learned and bring it to the Commission.

COMMISSIONER RILEY: I'd like to have the role of Chairman of the Jim Teisl Fan Club.

[Laughter.]

MR. TEISL: Granted.

COMMISSIONER RILEY: I know. I know.

I bugged him with written comments in advance, so I won't go over all of those, but I do think that it's really important stuff, and to lay it out in the framework of a very changing environment around SIM and DSRIP, and more all-payer kind of activities like the claims database is important. But I think the point being the framework here gives us a baseline in a time of extraordinary change in which we can sort of measure against the same set of criteria, which is really important, and I think it will be value-added.

So I think -- hear, hear -- it's tough work, but I think it's exactly the right way to go, and your diplomatic skills on Slide 6 are extraordinary.

CHAIR ROWLAND: I'd like to add one more criteria, if we could, to the framework, which is accountability. I think that we want to make sure that however we pay, there is accountability for what's delivered for that payment, and it's sort of implied there. But I think it's important to say directly that the payment system should have accountability built into it, so that if you are paying nursing home something, you know what kind of care is being delivered, and that the payment is linked to outcomes, which is the direction many of these new demos are trying to move, but we'll see.

Andy and then Steve.

COMMISSIONER COHEN: Great work to both of you. It's a really good chapter.

This sort of goes a little bit against, oh, say, the statute that sets up the Medicaid program and our charge, but I, nonetheless, think that we should just think about it. And it really came up in the context of

premium assistance where we are kind of looking at the cost implications to Medicaid of premium assistance. On one hand, we have a sense that, in many cases, the plans in the provider networks that we might be buying premium assistance are more expensive than what Medicaid in fee-for-service or managed care has typically provided. But, on the other hand, there's issues around risk pool and growth of a risk pool and things like that, that might be mitigating.

And I think it just requires us to at least acknowledge in our analyses that something -- you know, a change might not necessarily be cost effective or efficient for Medicaid, but potentially could be cost effective or efficient for the payers into Medicaid, who are both the federal and the state governments, and maybe in different measures or proportions. But I do think it's important for us to just sometimes step outside our bureaucratic boundaries if we're not allowed to do it for purposes of a recommendation. We can at least think about it in terms of analysis and just not be sort of blindly kept in the box that we are in, because a solution that might be more efficient for the system and the government payers as a whole may not necessarily look efficient for one slice of it. So I just think that's an important thing to always keep in mind.

CHAIR ROWLAND: Steve.

COMMISSIONER WALDREN: I like Patty's discussion around transparency. I do think there are some concerns about transparency in regards to making sure that the data is accurate and that it's in good context.

Maybe one thing that we could do in the interim, though, is if we added transparency to the framework. How transparent is the payment? You can start to call that out and show places that maybe

we can make some recommendations on improving transparency, although I hate adding more things to the evaluation framework.

CHAIR ROWLAND: Donna.

COMMISSIONER CHECKETT: You know as well as I -- and I am going to have to arm-wrestle Trish, and I don't know who is going to win on that one. But, seriously, I think lots of us really enjoy the payment work. It is very important work because, at the end of the day, really the ability to pay or not for pay for services is why we have this extraordinarily convoluted Medicaid program. I mean, who is going to pay for people who can't pay for themselves? So I think it's really important work, and I so enjoy the structure.

I have actually one question, and I am really serious about it, but as a goal, I like the goal of being fair. I don't know how you decide what's fair, and so I just put that out there for a question. I have a feeling that what I think is fair would not be what someone else with an equal seat at the table thinks is fair. So it's a little -- I just want you guys to think that through.

And the framework, I am not an artist either, but I don't understand. If we're saying efficiency, is it the heart in that access, quality, and economy are supporting it, then I don't know that we're saying that clearly with this diagram. And if the diagram is really just illustrative for the purposes of today and it's not going to be a centerpiece of the article, I'm okay with it, but if we're going to really run with it and use it a lot, then I think we probably need to really rethink a little bit how it's laid out. But thanks for the great --

CHAIR ROWLAND: And we may really need to get an interactive where it's all up on the Web and not on a flat screen.

COMMISSIONER CHECKETT: Yeah, yeah.

MS. FORBES: We were trying to collapse several slides, and Jim made the graphic. So I just want to get that on the table to balance out --

[Laughter.]

MR. TEISL: And I am also not an artist.

COMMISSIONER CHECKETT: So you get to be the head of the other fan club.

Thank you.

CHAIR ROWLAND: Okay. Sharon.

COMMISSIONER CARTE: Donna, to the point you just mentioned about fairness, it's true that what one person regards as fair might not be another person's plate, but what about equitable? I mean, wouldn't we want to know what services a Medicaid child gets are equitable with those in a private plan?

COMMISSIONER CHECKETT: I think that's different from fair, though, but that's just my opinion.

COMMISSIONER CARTE: Can we put "equitable" on there?

CHAIR ROWLAND: Well, the statute gives us "assure access equal to the general population", so "equitable" is already built in right there.

MR. TEISL: Yeah. And I just want to point out really quick, I mean, with that list of sort of other priorities, we were sort of trying to capture all of the things that policymakers might think about that don't fit as neatly in, though I agree, obviously, fairness is a pretty difficult thing to evaluate objectively.

CHAIR ROWLAND: But we know administrative simplicity is at the top of the list, and that's the

condition's main contribution.

Other comments?

[No response.]

CHAIR ROWLAND: Okay. I think this is a really good start. Obviously, we have made more progress on this framework than we did on our initial access framework, so you are delivering in a very timely manner, and I do think it's important that we have sub-criteria as we look at these changes in payment and other payment policy initiatives to be able to say this is what we're looking for to see how it works against this set of issues, and so I think this framework does start as on at least patch being able to say how we evaluate things, so thank you.

And now we will take a 10-minute break and then reconvene.

* [Recess.]

CHAIR ROWLAND: If we could reconvene, please.

Katie, thank you. We are going to turn now to look at some of the other side of the coin on cost sharing and affordability by looking at the Medicare savings programs and their relationship to Medicaid, and Katie is going to take us through the next stage of our discussion.

POLICY OPTIONS FOR IMPROVING ACCESS TO CARE AND REACHING OUT-OF-POCKET COSTS FOR DUALLY ELIGIBLE BENEFICIARIES

* MS. WEIDER: Great. Thank you.

So before we get started, I will start with a brief outline of what we will be reviewing today. First, we will review the past Commission's work on access to care and costs for dually eligible beneficiaries.

Then we will examine policy options related to these issues, and finally, we will review next steps in which we are looking for your feedback specifically on these policy options.

What we need your feedback on is more information, if you need more information on what's presented today, and based on your discussion and consensus, we can come back to you with more evidence or refine these policies options into recommendations for an upcoming meeting or report.

Before we dive into the policy options, we want to provide a brief overview of what our past work was. You will recall that in MACPAC's March 2013 report, we documented that 39 states use the lesser of payment policies for Medicare payment of Medicare cost sharing.

We built off this work at our last Commission meeting in October in which we presented the different MSP categories, MSP eligibility and enrollment issues, as well as the inefficiencies of Medicaid paying for Medicare cost sharing.

During the last Commission meeting, we also presented findings from our study that suggests that lower Medicaid payment of Medicare cost sharing is associate with lower Medicare service utilization among dually eligible beneficiaries relative to Medicare-only beneficiaries.

And finally, during our last Commission meeting, we briefly presented policy options, and today, we will provide more information specifically on their rationale and potential impact on stakeholders.

So building off of this past work and located in Tab 5 of your binder, we provide new background information, which I will briefly highlight now, and I first want to turn your attention to page 5 of the background paper.

You will recall that in October, we specifically looked at change in the predicted utilization of

selected Medicare services when moving Medicaid payment from 66 percent of the Medicare cost-sharing amount to 100 percent of the Medicare cost-sharing amount, and as discussed at the meeting, not all states pay 66 percent of Medicare's rate for Medicare cost sharing. Some pay more, and some pay less.

In the table on page 5, in the background paper, we present new information about how utilization rates vary based on Medicare cost-sharing payment percentages. As expected, the lower the Medicare payment percentage, the greater the change in predicted utilization when moving to the full 100 percent of Medicare cost sharing.

For example, at our last meeting, we showed you that moving from 66 percent of Medicare cost sharing to 100 percent of the Medicare cost-sharing amount results in a 2.3 predicted percentage point increase in the utilization of outpatient evaluation and management services for dually eligible beneficiaries relative to Medicare-only beneficiaries.

Our new work shows us that if you move from 20 percent of the Medicare cost-sharing amount to 100 percent of Medicare cost-sharing amount, there is a 5.3 predicted percentage point increase in the utilization of outpatient evaluation and management services for dually eligible beneficiaries relative to Medicare-only beneficiaries.

Another new issue that we present in our background paper is how state payment procedures and payment amounts for Medicare payment of Medicare cost sharing differ based on fee-for-service and Medicare Advantage enrollment.

It's also important to recognize that providers cannot balance-bill for any outstanding portion of Medicare cost sharing that Medicaid does not pay. However, institutions, such as hospitals and FQHCs,

can receive bad debt payments to recoup some of these costs.

This being said, there is a foundation to support increasing payments to providers for the unpaid Medicare cost sharing, which is further supported by the fact that, one, dually eligible beneficiaries are among the sickest and poorest Medicare beneficiaries, which makes them particularly vulnerable to access barriers. Two, unlike Medicare beneficiaries, dually eligible beneficiaries are subject to the effect of state payment policies on provider practice patterns. And three, as previously mentioned, research suggests that lower Medicaid payment of Medicare cost sharing is associated with lower Medicare service utilization among dually eligible beneficiaries relative to Medicare-only beneficiaries. And we've seen some of these largest utilization effects specifically in primary care, which is particularly noteworthy, because there has been a recent federal policy focus on increasing primary care provider payments in order to improve access to care. And finally, five, Medicare is already paying for some of these uncompensated care costs through bad debt payments.

So here, we present three potential policy options for increasing provider payment, and I will review them in more detail in the upcoming slides But the first option is having Medicaid pay the full amount of Medicare cost sharing on behalf of dually eligible beneficiaries for targeted services. The second option, which is slightly different, has Medicaid pay the full amount of Medicare cost sharing on behalf of dually eligible beneficiaries for all services And the third option is that Medicaid pay for Medicare cost sharing on behalf of dually eligible beneficiaries.

So, on this next slide, we are presenting both policy options 1 and 2. Both options require states to pay the full 100 percent of Medicare cost sharing, which increases provider payment and is likely to result in

an increased access to care for dually eligible beneficiaries. However, these options differ in the fact that different beneficiary groups are targeted. Option 1 would increase provider payments for selected services, which would only impact beneficiaries who utilize certain types of services or provider types. In option 2, provider payment is increased for all services, which would impact all dually eligible beneficiaries, regardless of health need.

However, for both of these options, there are two methods to financially structure increasing provider payment through Medicaid. The first financing mechanism would be to require states to pay the full 100 percent of Medicare cost sharing for dually eligible beneficiaries, but continue to provide states their current match rate. This would place a significant financial burden on states and could lead states to scale back other aspects of Medicaid benefits or MSP eligibility. Furthermore, states would be affected by this requirement differently. States that already pay the full 100 percent of Medicare cost sharing would not be financially affected at all, while states paying a low Medicare cost sharing would be greatly affected by this change.

But our second financing mechanism is to require states to pay the full 100 percent of Medicare cost sharing but also increase the state's federal match, which could either be 100 percent federal match or just an increased federal match rate. In this scenario, the financial burden on states to pay the full Medicare rate for cost sharing would be reduced, but this method would increase cost to the federal government. This method also allows states with more generous MSP eligibility levels to maintain their higher thresholds, and states could use their cost savings for a variety of purposes, including offering additional services under Medicaid, which would benefit both dual eligibles and Medicare-only beneficiaries.

So if the Commission is interested in considering these options for recommendation, it would need to decide if one, all, or some beneficiaries will be affected. And, two, if states should receive an increased federal match.

CHAIR ROWLAND: I think this is where fairness comes in.

[Laughter.]

CHAIR ROWLAND: Especially to those states that are already providing coverage at 100 percent.

MS. WEIDER: So our third option here is option 3. It is requiring Medicare to pay for Medicare cost sharing for dually eligible beneficiaries. We are presenting this option, even though it's beyond our statutory authority to recommend to show how option 3 differs from the first two options which use Medicaid as a lever for change.

One major difference we would like to highlight is how Medicare payment for Medicare cost sharing removes the administrative burden of passing provider claims between Medicare and Medicaid. This would reduce administrative burden for states and improve provider billing processes. This reduction in administration burden is then likely to reduce cost to states; however, like the other two options, it's likely to increase cost to the federal government.

Now I will take your questions regarding these policy options at the end, but, first, I am going to just briefly review MSP eligibility and enrollment policy issues and policy options.

So, as you know, MSP enrollment has been historically low. But when we are talking about MSP eligibility and enrollment, it is also important to bring up the Part D low-income subsidy program, the LIS program, specifically for two reasons.

The first is that eligibility for the Part D LIS program and the MSPs are linked. As you know, the Part D LIS program helps pay for Medicare Part B premiums and cost sharing for low-income Medicare beneficiaries. MSP beneficiaries are automatically deemed eligible for the LIS program and automatically enrolled. Others who do not automatically qualify can apply through the Social Security Administration.

The second point we want to bring up regarding the Part D LIS program is that despite this linked enrollment efforts and efforts to align these programs, different asset levels and income levels for LIS and MSP eligibility has created inconsistencies across these programs. This leaves room for improvement in both programs' eligibility processes.

So this being said, there is a foundation to support expanding MSP eligibility and improving MSP enrollment, which can boil down to the fact that, one, enrollment can be increased by expanding eligibility thresholds, increasing education and outreach, and improving the enrollment process. And two, improving MSP application processes would decrease administrative burden to states.

So here, we are proposing five potential policy options for MSP eligibility enrollment, which include, one, eliminating asset test for MSP enrollment; two, permanently funding the qualifying individual program, the QI program; three, expanding the QI program; four, increasing support for MSP education and outreach; and five, creating a single eligibility determination for the Part D LIS program and the MSPs.

Now, there are other options that can be explored to address MSP eligibility; however, any recommendation that would affect full-benefic Medicaid eligibility was beyond the scope of our discussion today.

And we also want to point out that all of these recommendations require an increase in spending

and aim to increase a number of beneficiaries enrolled in the program. So in the next five slides, I won't be highlighting what they have in common, but instead focus on the differences between these options.

So our first option is to eliminate asset test for MSP enrollment. It's important to recognize that although this will benefit dually eligible beneficiaries whose assets are currently too high to qualify for the MSPs, it will also have an impact on the Part D LIS program. In theory, the Part D LIS program is a separate federally administered program with a federal application process through the Social Security Administration. However, as mentioned before, MSP beneficiaries are automatically deemed eligible for Part D LIS. So if MSP asset tests were removed, there would be an increased number of MSP beneficiaries who are also eligible for Part D LIS, and currently, the LIS program has an asset test for those who do not automatically qualify. So certain beneficiaries would still be subject to their current asset-level thresholds for LIS eligibility. This option would create disparities in LIS eligibility, which would exist in all states if a federal requirement to eliminate MSP asset test was not also coupled with the provision to do so as well in the Part D LIS program.

In addition, this option does not eliminate asset test entirely for the Medicaid program. Individuals applying for a full benefit in Medicaid in addition to MSP assistance and who are also not eligible for MAGI face a complex income and asset test for Medicaid eligibility. So eliminating asset tests for MSPs does not address this underlying complex application process to receive full-benefit Medicaid.

Our second policy option is to permanently fund the qualifying individual program. You will recall from our last meeting that the QI program covers Part B premiums to over 576,000 Medicare beneficiaries with incomes between 121 and 135 percent of the federal poverty line. The QI program is entirely

federally funded, and funding is allocated yearly and dependent on periodic congressional reauthorizations and appropriations.

The program is currently scheduled to terminate on March 31 2015. Permanently funding the QI program would end the perennial uncertainty for states and beneficiaries on whether the program will continue without increasing cost to states.

And our third policy option is to expand the QI program. MedPAC recommended expanding the QI program to 150 percent of the federal poverty line, which aligns the MSPs and the LIS income levels. MedPAC cited that this recommendation provides direct assistance to low-income beneficiaries and is more efficient than increasing payments to providers. However, one important point to recognize is that under this option, some beneficiaries may lose their medically needy Medicaid eligibility. Out-of-pocket costs can cause some beneficiaries to spend down to a state's medically needy income limit and gain Medicaid eligibility. If the QI program was expanded, out-of-pocket cost would be eliminated, resulting in some beneficiaries losing their Medicaid coverage.

Our fourth policy option is to increase support for MSP education and outreach. Research suggests that raising awareness of the MSPs is likely to increase the number of beneficiaries enrolled in the programs. Efforts like this have been done in the past. The Medicare Improvements for Patients and Providers Act of 2008 provided $5 million from the Medicare Trust Fund to the Aging and Disability Resource Centers, the ADRCs, to be used for MSP and LIS education and outreach.

And our final policy option is to create a single eligibility determination for the MSPs and LIS programs. We are proposing this option because it could increase the number of low-income Medicare

beneficiaries receiving MSP assistance and also decrease beneficiary burden. We also propose this option because it's consistent with the Commission's desire to simplify Medicaid policy whenever possible. However, there are issues that would defy simplification for all low-income Medicare beneficiaries, which include the fact that MSP applicants who want a full-benefit Medicaid determination may still need to provide states with additional income and asset information And two, some states currently use MSP eligibility levels that are more generous than the LIS program, which would lead them to maintain their own MSP application process if the Social Security Administration uses the federal but not state-specific MSP levels.

So, finally, we can end with next steps, and as I mentioned in the beginning of the presentation, we are seeking your feedback on these options presented today, and based on your discussion, we can provide more information, evidence, or develop recommendation language for an upcoming meeting, which both can be incorporated into a chapter for an upcoming MACPAC report.

And from here, I can answer questions, and we can begin today's discussion.

CHAIR ROWLAND: David.

VICE CHAIR SUNDWALL: Thank you. This was a really wonderful overview of an issue that we've been wrestling with since we started. Dual eligibles are a challenge for all the reasons you've identified.

I understand that it's well beyond the scope of MACPAC to tell what Medicare policy should be, but it seems to me your presentation begs for a solution that would merge Medicare and Medicaid for the dual eligibles. That's something we can't recommend per se, but we can document through the work that you're

doing the benefits of that administrative simplification and fairness which we're talking about. It seems to me such a complicated maze they must navigate, and the numbers of people engaged in assessing and calculating and all these policies. So I think it's really nice to have this laid out this way. And I know we're not voting yet on recommendations, but I sure like policy option number 5.

COMMISSIONER HOYT: I agree with David's last comment. I think there's a lot of intuitive appeal to begin simplifying, doing the single eligibility determination for both those programs. It seems like we maybe also have a decision to make since MedPAC is on record as recommending the QI program be expanded. We should say we agree or not. I don't know. But I'd be in favor of that as well as permanently funding the program. I guess we need to get CBO estimates first so we know what we're talking about. But I'd be interested in seeing that.

COMMISSIONER RILEY: You've done a wonderful job with an extraordinarily complicated issue. When I read your paper, I couldn't sleep because I remembered crossover claim discussions. And it was like, "Oh, it's so hard to understand." And I think the paper could be stronger on the state perspective, because I think there are issues of equity about the state and how the state treats Medicaid beneficiaries. And if you treat the subset differently who get Medicare in addition to Medicaid, it creates a different set of conflicts, not just budgetary. And even on option 5, that's probably a good example, where if you have to have the full benefit, you have a different -- it's not unlike MAGI and all the rest of it, but it further complicates the program. And it increases the number of beneficiaries enrolled in MSP, so that increases state costs. And I think we just have to be really clear in our impact on states there.

So my inclination would be to say this has gone round and round long enough, and it may be that

Medicaid can't solve this. Medicaid may not be the vehicle for this policy discussion.

CHAIR ROWLAND: It also seems to me that we're trying to address two very different things here. We're trying to address at the very beginning the results of a study that says if you don't pay the full share of Medicaid -- Medicare cost sharing, that you are impeding access to care and services by low-income dual eligibles, which has one set of policy options to it.

The second piece here is then who should get assistance with Medicare cost sharing and should that be through this series of three different kinds of programs where some people only get help with premiums, so the cost-sharing policy is irrelevant for that group. The next group gets premiums and cost sharing but no benefits. And then the last group isn't even an entitlement, it's an appropriated program. So that there's an issue about how to streamline just how to handle those three groups, and then the third issue is and who should be paying for these changes or how should they be administered.

And I think if we look at it in those different buckets, we may come up with a recommendation with regard to the cost sharing that is very different from recommending a single entry point for the LIS and the Medicare savings programs.

COMMISSIONER MOORE: I just want to say that I think your clarification of those three is excellent, and the paper is very good as written, but it would really, I think, benefit from the very clear delineations as you've described them.

CHAIR ROWLAND: Other comments? It's a knotty issue.

VICE CHAIR SUNDWALL: I'll say.

CHAIR ROWLAND: I think also that just bearing in mind how many people are in these

different pots and what their income is goes to, you know, what we're doing here is the same as what we've been trying to do on children. It's to look at affordability, to look at how that differs by income. And, of course, I think the asset test is another kind of thorny issue here. We've eliminated it in many other places of Medicaid now, but the asset test for the Medicare beneficiaries has always been a part of determining nursing home eligibility and home and community-based services, too. So it gets complicated, and I think it's important to recognize the differences there between -- you mentioned medically needy people who would lose their medically needy eligibility, but if they're basing that on their spending for cost sharing and for drugs, then maybe if you fill it in, it doesn't matter that they're losing their medically -- so I think we need to really lay some of those consequences out.

COMMISSIONER COHEN: I agree with a lot of what has been said, and a really good presentation. I would just say that while this area really cries out for some work, there are a lot of things about, you know, the intersection of these two programs that doesn't make sense, that causes a lot of complications. I feel like picking off any one or two issues is not probably the best way to go because you're inherently leaving others, and there are lots of interactive effects. It's also quite costly, and I do think while I think we should all sort of take pause at the utilization information, you know, the impact of the payment policy on utilization, it is an issue that affects the entire Medicaid program. But we don't really know to what extent and how much of the utilization is the right utilization. We do know that it's mostly primary care, suggesting even more that it's probably care that shouldn't be deterred. But we don't really know for sure, and it's not different than the rest of the program.

So I am sort of inclined to think myself that this is an area that does need a bit of a comprehensive

look. I don't know how to do that sort of bureaucratically speaking, you know, with the differences in jurisdiction for recommendations between MedPAC and MACPAC. But I think it is very challenging to pick off one or two issues in this space. And I'm not sure that we have the strongest evidence for any one of them to really make it clearly more compelling than the access issues elsewhere in Medicaid.

CHAIR ROWLAND: I also think that on the QI issues obviously they will have to be considered in a March extender bill. And so we really need to think through, if we're asked to comment on the QI issues, what our position would be. And so I think the options you've laid out here about should we agree with the MedPAC recommendation that it be extended to 150, should we look at whether it should be a permanent authority or not would be other issues we might want to consider.

COMMISSIONER HOYT: So the QI people, if it was expanded and people lost Medicaid eligibility, no longer medically needy, they're duals, right? So they're still on Medicare, right? Okay.

CHAIR ROWLAND: They start on Medicare. It's whether they get Medicaid to wrap around Medicare.

VICE CHAIR SUNDWALL: It has always struck me as amazing that we use one insurance -- I mean one federal public program to wrap around another public program. It's like the right hand doesn't know what the left is doing. It's just startling to me.

CHAIR ROWLAND: Except it started with -- Medicaid was created to be the partner to Medicare, so it's a 50-year-old relationship with a lot of tweaks and changes along the way.

The other thing, of course, is that the change in how much was paid, what share of the cost sharing was paid, was a more recent legislative change, and so what we've really done there is to look at the impact

of giving states that flexibility. And it goes back to the fact that the states pay so little for their care that their payment rates were lower than the cost sharing.

Okay. Thank you, Katie.

And now we come to the part of our afternoon where we invite comment from the public on any of the issues that we are either addressing or issues we should be addressing that we have your guidance to add to our agenda.

PUBLIC COMMENT

* [No response.]

CHAIR ROWLAND: Shy people today? Okay. Well, with that we will adjourn this session, and we will reconvene in public session at 9:30 tomorrow morning. But the Commission members, if they would stay for a brief after-discussion.

* [Whereupon, at 3:39 p.m., the meeting was recessed, to reconvene at 9:30 a.m. on Friday, December 12, 2014.]

MACPAC

Medicaid and CHIP Payment and Access Commission

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, December 12, 2014
9:51 a.m.

COMMISSIONERS PRESENT:
DIANE ROWLAND, ScD, Chair
DAVID SUNDWALL, MD, Vice Chair
SHARON L. CARTE, MHS
RICHARD CHAMBERS
DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
BURTON L. EDELSTEIN, DDS, MPH
PATRICIA GABOW, MD
DENISE HENNING, CNM, MSN
MARK HOYT, FSA, MAAA
NORMA MARTINEZ ROGERS, PhD, RN, FAAN
JUDITH MOORE
TRISH RILEY, MS
SARA ROSENBAUM, JD
STEVEN WALDREN, MD, MS

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S [9:51 a.m.]

CHAIR ROWLAND: Good morning, and welcome to the next session of the Medicaid and CHIP Payment and Access Commission. We're going to begin our discussion this morning by having Martha provide us with an update on the pregnancy-related Medicaid and minimum essential coverage provisions, and this is one in which we've been inspired by Sara Rosenbaum to bring together the recent rulings and what their implications are.

So we are at Tab 6, and Martha will kick it off.

* MS. HEBERLEIN: Okay. Thank you and good morning. Sorry for the scratchy voice.

As Diane said, I'm going to give you guys an update on pregnancy-related Medicaid and minimum essential coverage. There's some recent guidance from CMS and IRS that has implications for the recommendations you made back in the March report.

Back in March you guys made two recommendations concerning pregnancy-related coverage in Medicaid, so I'll begin with a review of the issues that led to those recommendations as well as an overview of the new CMS and IRS guidance, as well as considerations for pregnant women when they're choosing their coverage, and the impact of recent guidance on Commission recommendations. And I'll ask that you help guide us as to what, if any, next steps you want us to take in terms of analysis.

So as a bit of a refresher, the benefit package may differ for pregnant women in Medicaid depending upon her eligibility pathway. States can provide full Medicaid benefits to women who are covered under

pregnancy-related pathways, but may limit services to those just related to pregnancy. So this is a state option, and as of September 2013, when we last looked at this, eight states -- Alabama, California, Idaho, Indiana, Louisiana, Nevada, New Mexico, and North Carolina -- were reported to cover only pregnancy-related services for most of their pregnant women.

So, on the other hand, coverage in the exchange through a qualified health plan is broader than pregnancy-related benefits. As I talked about yesterday, it covers the ten essential health benefits, one of which is maternity care. So it may provide a broader benefit package than that available to pregnant women whose state decides to limit coverage to pregnancy-related benefits.

On the other hand, QHP coverage may come with higher premiums and cost-sharing requirements that are typical in Medicaid and may not provide some enhanced services that are offered by some Medicaid programs, such as nutrition counseling and targeted case management and dental.

So, generally, individuals who are eligible for other insurance either through an employer or Medicaid that is considered minimum essential coverage, or MEC, are not eligible for QHP subsidies. They could still get a QHP, but they will not get the tax subsidies to help purchase that.

So previous guidance provided an exception for certain pregnancy-related pathways by not counting them as MEC. So the guidance that you based your earlier recommendations on specifically said that women who are eligible through a pregnancy-related pathway that allows states to limit their coverage to pregnancy-related benefits do not have MEC, regardless of whether the state chose to provide

pregnancy-related benefits or full-scope Medicaid. So across the board it was ruled as not MEC.

So for IRS purposes, these women were seen as uninsured and were, therefore, eligible to get QHP subsidies, as long as their incomes were above 100 percent. So women could be eligible for both pregnancy-related Medicaid and QHP subsidies.

However, because this coverage was not considered MEC, women could also be subject to the mandate penalty in the absence of an exemption. But at the same time, the 2014 penalties were waived by the IRS, but when you made your recommendation, there was a chance -- they were only waived for 2014, so there was a chance that they could be imposed in future years.

So the first recommendation you made back in March would require coverage of full Medicaid benefits for pregnant women who are eligible through either mandatory or optional pregnancy-related pathways. So this would basically end the option states had to provide pregnancy-related benefits and would ensure robust coverage to all pregnant women in Medicaid regardless of their pathway.

In addition, this would also exempt the women from being subject to the mandate penalty because if they all were provided the full Medicaid package, then the IRS could rule that it was MEC and, therefore, they would be not subject to the penalty.

The second recommendation would allow women who were enrolled in a QHP who then became eligible for Medicaid as a result of their pregnancy to stay enrolled in that QHP. So instead of -- if they become eligible for MEC, they would then have to move to Medicaid. Then when their Medicaid ended,

they would have to move back to the QHP. So the rationale behind this recommendation was to ensure continuity of coverage for somebody who was already enrolled in a QHP. And this would also allow for pregnant women to enroll concurrently, so in both QHPs and in Medicaid.

So moving on to the new guidance, in the November 7th letter CMS announced that pregnancy-related Medicaid will now be considered minimum essential coverage in states that provide full Medicaid benefits. So it's important to note that CMS will be making this decision on a state-by-state basis. And states now have to submit a state plan amendment that details their pregnancy-related coverage and whether it provides full-scope benefits or if it's just pregnancy-related services.

CMS will take a look at those states that indicate that they provide only pregnancy-related services as well as any other additional limits they may provide and then make a determination in those states as to whether full-scope Medicaid services are provided. So this will be a state-by-state determination.

At the same time, IRS guidance also provided some clarification which said that women who are enrolled in QHPs at the time that they become pregnant and eligible for pregnancy-related Medicaid can remain in their QHP. Basically they're only considered to have MEC for the purposes of premium tax credits if they actually enroll in Medicaid. So even though they are eligible, as long as they don't enroll in Medicaid, they are still eligible for their QHP subsidy and can retain it.

So this has some implications. So options as a result for concurrent enrollment have changed, and coverage for pregnant women, their options will now depend both on when the state -- what the state ruling

is in terms of whether the Medicaid coverage is considered MEC, whether the woman is pregnant at the time of enrollment, whether she is currently insured, and the time of year at which she applies.

So it's a little complicated, so I'm going to walk you through the scenarios, one looking at states where it is considered MEC and states where it is not considered MEC.

So starting with the states where coverage option for pregnant women is considered minimum essential coverage, this slide represents a graphic representation of women's coverage choices in states where Medicaid is considered MEC. And it shows based on her coverage status at the time of pregnancy what her options are.

The text in red shows you what options were previously available on which you made your recommendations that are no longer available under the new guidance.

There is also a more detailed table in your briefing materials that sort of walks through the before and after. So starting at the bottom, you can see if a woman is enrolled in a QHP at the time of pregnancy, she can remain in her QHP. However, she no longer has the option for a Medicaid wrap. In order to get Medicaid, she would have to disenroll from her QHP and enroll in Medicaid. And when her Medicaid ends, after the 60-day postpartum period, she would then have to re-enroll in her QHP.

So for those women who are either uninsured or in Medicaid already at the time of their pregnancy, they have the option -- well, they don't have the option. They are enrolled in Medicaid.

So similar to the previous slide, this slide walks you through what happens in states where Medicaid

is not considered MEC. In those states, pregnant women who qualify through a pregnancy-related Medicaid pathway will have a choice of enrolling in Medicaid or a QHP or both sources of coverage. Enrollment in a QHP, however, is only available to them during the open enrollment period or after a qualifying event. Pregnancy is not a qualifying event.

So I want to point out that this is the case of when you made your recommendation, this is the scenario across all states. And as I mentioned before, we think only eight states were providing limited pregnancy-related coverage before the guidance was released, so where women will have these options is going to be limited, and that also depends upon whether or not CMS decides these states are providing full-scope benefits even if they are indicating they are limiting them.

Finally, the guidance made clear that women who choose to enroll in Medicaid coverage that is not recognized as MEC will continue to have an exemption from the mandate penalty by securing a hardship exemption, so it's not just an exemption for 2014. This is an exemption going forward. So they're protected from the mandate penalty. If they enroll only in Medicaid, they don't have to get subsequent coverage.

Yes, they have to apply and get the exemption. It's not...

So some of the things that we think are important for women to consider when they're choosing their coverage choices or when they're thinking about their options. A pregnant woman may want to take into account the comprehensiveness of the benefit package and whether it includes services beyond those

related -- just the pregnancy. So pregnancy-related services are likely to be comprehensive and pretty comparable between Medicaid and QHP coverage, although, as I mentioned before, Medicaid may provide some enhanced services in certain states.

Conversely, a QHP must offer all essential health benefits, so may offer a more robust package for women in states where their coverage would be limited to pregnancy-related services.

The cost of coverage, including premiums and other cost sharing, will also likely make -- be a point or consideration for women. Women who qualify for pregnancy through -- sorry, qualify for Medicaid through a pregnancy-related pathway won't have to pay premiums for that coverage, and cost sharing is not allowed for pregnancy-related care.

For QHP coverage, women may qualify for a premium subsidy if they're between 100 and 400 percent of the FPL. However, this subsidy may not cover the full cost of the premium. And some preventive health and prenatal care benefits are covered with no cost sharing, but cost sharing is allowed for hospitalization for delivery.

Also, transitioning plans during the year could affect continuity of care. In some cases, changing coverage options would require a woman to switch providers, which may be especially burdensome for women with chronic care or other ongoing health concerns.

In addition, churning could be difficult and confusing for enrollees as well as administratively complicated for the Medicaid program, the exchange, and the plans.

Changes in coverage could also affect coverage options available to the woman's family. In Medicaid, the addition of a pregnant woman to the household could result in a change in eligibility for other members while for QHP eligibility the amount of the subsidy would change depending upon the number of people enrolled in the plan.

Finally, it is not clear whether states have enabled women to enroll in both QHPs and Medicaid simultaneously and, if so, whether they were able to provide the cost-sharing and benefit wrap that these women were entitled to. So the ability to enroll in both plans would negate the coverage for transition between coverage sources over the year or during the course of pregnancy and would also allow the women to receive the full scope of benefits provided as well as the cost-sharing protections available in Medicaid.

So the impact of the guidance on your recommendations. As I mentioned, requiring all states to provide a full Medicaid package to women would have ensured robust coverage and eliminated the potential for a mandate penalty. The guidance does not affect states' ability now or in the future to limit coverage to pregnancy-related services only. However, it does extend the penalty exemption beyond the current year going forward. So, therefore, any woman who enrolls in pregnancy-related coverage that is not considered MEC is exempt from the penalty even if she does not enroll in another source of coverage.

So as for the second recommendation, the Commission's intent was to allow women who were already enrolled in QHPs when they became pregnant to retain that coverage, even if they became eligible for Medicaid, thus reducing churning over the course of the year. And so the recent guidance does address

this to some extent, as I mentioned, where it does allow a woman who is enrolled in a QHP at the time she becomes pregnant and eligible for Medicaid. As long as she does not enroll in Medicaid, she can remain in that QHP with her subsidy. However, it does not allow women to secure both sources of coverage, which was important to the Commission. But in states where Medicaid is not considered MEC, she still has the option to enroll concurrently in those sources of coverage, so this depends upon the state.

So based upon your interest in this topic, staff can provide some additional analysis. So, specifically, we can monitor CMS decisions regarding which states pregnancy-related coverage is considered MEC. According to our previous work and what was released in the guidance, the vast majority of states indicate that they provide the full Medicaid package to pregnant women, so it is likely only a few states will be able to have concurrent enrollment.

Staff can also look more closely at the states where this concurrent enrollment has occurred and whether women have been able to successfully enroll in both programs. It could provide helpful information for us in our other work, including premium assistance as well as looking at the future of CHIP and whether wraps work generally. It is also, I think, interesting to learn more about how women were informed and educated about their choices as well as whether the coordination of benefits and cost sharing and what the administrative work to coordinate those was.

Finally, while information on the practical effects of the change in eligibility options is limited, we could investigate whether there are data available to provide a more thorough assessment of the number of

women who are eligible for both options, the number of women churning between coverage sources, and what the timing of those changes are.

So I look forward to your questions and to your suggestions for going forward.

VICE CHAIR SUNDWALL: Thank you. Another outstanding example of the complexity of Medicaid. Makes your head spin.

My question is, on the eight states that have chosen to limit coverage to just maternity benefits, is there any cost analysis to how much it would have cost them if they had been more generous, or is there an economic rationale for why they made that choice?

COMMISSIONER ROSENBAUM: The eight states --

VICE CHAIR SUNDWALL: No. I thought it was the eight states that had limited coverage. I mean, that's what I understood, that they had limited it at only pregnancy coverage, not the full range of benefits. Did I misunderstand it? Is it the other way around?

COMMISSIONER ROSENBAUM: No, you're right. You're right. That's why I was sort of trying to -- my understanding is that in those eight states, they feel that the package that they have created is a sufficient package of benefits. I mean, I don't think it's any more particularly complex than that.

So the decision about are there things that we would cover otherwise -- for example, if you're a state, all of this briefing this morning about the new policy, as Diane said, is something that I asked be added to the agenda because of some work I did in California. In California, for example, the state extended dental

coverage. The state extended additional premiums in cost-sharing assistance. They had other benefits that they felt were very important during pregnancy, and so they gave women the full benefit. I think it's just the state's desire about whether they go partial and full.

And to me, the thing that really has me very worried is that, although the news is somewhat sketchy, it's not clear exactly. It is clear in the briefs in the King case, but it has not been made publicly as clear as it could be.

The maintenance of effort provision for adults is done. The Administration considers the MOE done, which means that in a state that is up to, say, twice the federal poverty level for pregnant women, you can't really supplement the benefit, and what you are going to set off is a whole lot of shuffling back and forth. It is not clear to me why a state would continue coverage above the 138 percent mark, and this goes to the issue that we have been grappling with as a Commission now for several year, which is this enormously important issue that Martha put her finger on, and that is, does Medicaid play an important role going forward for certain special need populations as a supplement to a standard employer, typical employer benefit package, sold in the exchange.

We could use a medically frail standard to keep backing people out, but another way to think about Medicaid moving forward is that, actually, a lot of people can go into the exchange, get their standard coverage, but then get supplemental coverage.

I can't think of any more important period than pregnancy for all kinds of pivotal supplementations,

most importantly oral health followed by -- and this was the California case study. We did a California case study on this and discovered that when you really did a deep dive between qualified health plan coverage and Medicaid, what came out was oral health, additional cost-sharing protections and premium protections, a lot of psychosocial care, including psychosocial treatments that have no comparable code in standard qualified health plans, a network of providers that specialize essentially in an unusually comprehensive level of care for women with the special high risks.

And we suggested, of course, that the way to deal with this was to treat Medicaid as a secondary payer to those, add them as a network option, essentially an out-of-plan network option, have a standard payment for a qualified health plan services made to these special providers, and then have Medicaid as a secondary payer for the extra services that were not part of the bundled qualified health plan rate.

This policy, it seems to me, just has put the issue of knitting the financial penalty side of the whole thing together, over and above the question of what do we do for pregnant women, what do we do for high-risk pregnant women who should not be made to disenroll and reenroll and disenroll and reenroll from their plans. Plans should not put up with this. Families should not put up with this. All the spillover effects on families should not happen.

Instead, CMS and IRS, in my view, should use their flexibility to say, "When it comes to pregnancy-related coverage, it doesn't matter if a state does this level of benefits or this level of benefits. For MEC purposes, we're going to treat it all as non-MEC," and then states, if they want to continue with

the additional coverage, can. If they want to enrich the coverage, they can, but women do not have to move out of their plans.

I think this throws -- if the Commission is going to be concerned about consumers first and foremost in all of this, this is just a really damaging policy, in my view, and I think we should comment on it. I think we should not simply do some more research on it. I think we should comment on some of the other options that might have been present to the agencies and what in our view this may set off.

COMMISSIONER GABOW: I have several comments that's sort of connecting maybe both of these and some other questions.

Given how important pregnancy is in creating the next generation of Americans who are healthy and given that you know when it begins and when it ends and given that Medicaid pays for over 40 percent of all births, this whole discussion should be, in flashing red lights, simplify.

I mean, this should not be an area that has become so complex, nor should it be an area in which there is no standardization of what it means to have coverage if you're poor and pregnant in America. So I think this is really bad.

The second thing I would say is can we or should we talk about the feasibility of saying pregnancy is a qualifying event. Would that be helpful? I mean, it's an event, beyond any doubt, and without this event, there would be no one sitting in this room.

[Laughter.]

COMMISSIONER GABOW: So, I mean, I don't know what the ins and outs of that are, but I just raise that, "Would that help?" is sort of one question.

The second question I would ask that I wasn't clear about --

CHAIR ROWLAND: Patty, I think that this adverse selection problem is where this comes up, that if you make pregnancy a qualifying event, people don't go and get insurance until they have that qualifying event. It is perhaps one that you would want to say is okay, but it does raise the adverse selection issue.

COMMISSIONER GABOW: But now that there is a mandate to get coverage, I just think I would like to peel that onion, and maybe I just don't understand all the nuances.

The other question I had, Martha, is, if you're in a QHP and you get pregnant and you are eligible for Medicaid and you disenroll and then you want to reenroll after your coverage period, do you have to wait for open enrollment again?

MS. HEBERLEIN: No. If your coverage is considered MEC and you disenroll from your QHP, you have to wait until your Medicaid coverage ends, and so you would have to wait until the 60-day postpartum period, as before --

COMMISSIONER GABOW: But you wouldn't have to wait until open enrollment?

MS. HEBERLEIN: No. You'd have to wait for your 60-day or open enrollment if you miss your 60-day qualifying event period.

COMMISSIONER ROSENBAUM: But the baby, meanwhile, would be in the QHP.

MS. HEBERLEIN: Depending upon your income level, the baby would deemed eligible for Medicaid.

COMMISSIONER ROSENBAUM: So the baby would also have to be reenrolled.

MS. HEBERLEIN: No. Because if you're a deemed newborn, you get a year of coverage.

COMMISSIONER ROSENBAUM: So you'd get your newborn coverage, but now the mom wants to go back into the qualified health plan. Is she going to take her baby back into the qualified health plan?

MS. HEBERLEIN: No, the baby will stay out on Medicaid.

COMMISSIONER GABOW: Yes.

COMMISSIONER ROSENBAUM: Oh, right, right. If it is a higher income standard, yeah.

MS. HEBERLEIN: And if you are in a Medicaid that is not considered MEC, the birth of your child would serve as that qualifying event, so you would have an enrollment period that would align.

COMMISSIONER ROSENBAUM: So the state now, then, in this system -- I mean, this is why I am so worried about states just panicking and rolling back their coverage, because now you have not only pulled the mother out of the qualified health plan and made the state the first payer during the pregnancy period, but now the state is the first payer again for the baby. So if it's a high-risk birth, what state would want to expose itself for women who are now operational, their coverage is optional, who are outside the

maintenance of effort provision?

I think this is one of these cases where nobody has thought about the dominoes that will fall, as opposed to giving a state the flexibility to enrich the coverage for a mother and her infant, we have now potentially set off a trigger to encourage every state to roll back its coverage, at least for women over the age of 18.

CHAIR ROWLAND: I think one of the things that would be helpful here is to also, as we think through this, look at the differences for the women who are below 138 percent of poverty who are already required to be on Medicaid and get full benefits, even in the states that have not elected to expand coverage, because that's part of an original mandate, and then to look at what the implications are for the women in the next tier up, because I think we need to make sure we are not mixing up the mandatory Medicaid population with the optional population.

But I think further analysis of who is here and what's at risk is something that the Commission really needs to look at and weigh in on, and that we can hopefully have a little more clarity and some issues where we might want to go to recommendations for the January meeting.

COMMISSIONER EDELSTEIN: And as Sara pointed out, even in the mandatory population, there's not a full range of benefits because, in most states, there wouldn't be --

CHAIR ROWLAND: There's no dental.

COMMISSIONER EDELSTEIN: And for pregnancy, that is a significant impact.

CHAIR ROWLAND: Well, Burt, maybe in your honor, we will make a recommendation that dental be added to the pregnancy package.

Thank you, Martha.

You know, the one thing we know is that even when Burt's voice isn't directly at the table, it will be echoing in our ears through every one of our discussions.

VICE CHAIR SUNDWALL: While Moira is coming up, can I just ask you? Utah does cover dental health when you're pregnant. How many states do? I know it's optional, but that's something that we consider a benefit.

COMMISSIONER EDELSTEIN: There's a handful of states -- I believe it's three to give -- that cover dental only for pregnant women. There are a number of states that have variable levels of dental care, something that the staff is now looking at. So pregnant or not, those adults would have some level of dental care.

CHAIR ROWLAND: Okay. We are going to now turn to look at a managed care update. Obviously, this is a very important topic for the Commission. Managed care is a primary delivery system for many of Medicaid's beneficiaries and growing in most states to cover increasingly frail populations that go beyond the pregnant women and children that had been covered in the past.

So Moira will give us an update on CMS's work and where we are going with our managed care work.

MANAGED CARE UPDATE

* MS. FORBES: Thanks, Diane.

We haven't talked broadly about managed care and its role in the program for about a year. At the last meeting, we had an expert panel invited to talk specifically about access in managed care, and afterwards, we had some discussion about the proposed rulemaking on managed care, and you had asked for an update on the program and on our activities.

So we don't know yet what will be in the regulation. We assume that it will cover the entire waterfront. CMS has done some signaling about what will be in it.

So, today, we have prepared a summary of some of the big issues in Medicaid managed care that have emerged since the last regulation was promulgated. We have also identified some overarching issues for you to start thinking about, and when the regulation comes out -- we hope it will be in January -- we will come back with more information on exactly what's in it and provide some supporting analysis to help you think through what the Commission might want to say.

So just to recap, MACPAC has done, actually, a lot of work on managed care. The June 2011 report focused exclusively on managed care, and it covered populations, access, quality, payment, program integrity, and data.

Since then, a lot of our work has focused on sort of pieces of managed care. We have looked at specific populations and services. We did a chapter on rate setting for integrated care plans serving

Medicare and Medicaid dual eligibles. Last month, I think it was, Kristal presented on findings from our site visits to states that are including managed long-term services and supports in their managed care programs.

We have done a number of research projects. We did a long study on state and federal oversight policies and standards for Medicaid managed care. We convened a roundtable of policy and technical experts to talk about managed care rate setting, and April has presented some work we have done looking at encounter data and the extent to which our data is usable for analysis.

And we've had a couple of expert panels over the years. Early in 2013, we had some health plan executives come and talk to you about their perspectives on the state enrollment process. Last fall, we had some researchers come and talk to us about alignment between Medicaid managed care and the QHP rules, and obviously, last month we had folks from the OIG and CMS and the State of Virginia to come to talk specifically about access. So we have been doing a lot. We haven't really done anything big, but we have been continuing to examine managed care issues.

So the new regulation is anticipated in early 2015. It was on the OMB's docket for this December. It's my understanding that it should be coming out, if not in January, then hopefully in February.

Medicaid managed care programs, just to give you some background since it's been a while since we've talked about this and since we didn't include a written summary in your packets, please bear with me. I am going to try and give a little bit of background verbally here.

Medicaid managed care programs are regulated by Title 42 of the Code of Federal Regulations, Part 438. It was first proposed in 1998 to implement the provisions of the Balanced Budget Act of 1997, which was the first time that there was a statutory option for Medicaid managed care. There were a couple of rounds of revisions, and the final regulations were promulgated in 2001.

There have not been significant changes to the regs since then. There have been a couple of things added and changed as things were added in various statutes over the years, and there have been some changes to the underlying guidance, but the reg has pretty much been the reg since 2001, which is a long time for a program that has seen as much growth and change as we have in Medicaid managed care.

One thing I want to make sure I mention is that in 2009, the CHIP Reauthorization Act extended the statutory Medicaid managed care provisions to CHIP. So when changes are made to the Medicaid managed care regulations, they are also going to apply by reference to CHIP managed care. So throughout this presentation, I am just going to keep saying the word "Medicaid," but keep in mind that that will also carry through to CHIP.

So, as I said, there have been a lot of changes to Medicaid and to managed care since 2001. Obviously, a lot more states use managed care now than did 15 years ago. They enroll more people. They enroll more complex populations. They include a lot of services that were not traditionally part of managed care. So there's been a lot of growth in this, and it is the dominant delivery system in terms of the number of people enrolled in Medicaid now.

In addition, the overall managed care marketplace has changed a lot. The Medicare Modernization Act of 2003 made a lot of changes that accrued to the Medicare Advantage program, and there's been a lot of growth in the availability of Medicare managed plans, a lot of rulemaking on that side. Obviously, Medicaid has a lot more dual eligibles who are being served by both Medicaid managed care and Medicare managed care. The ACA created both a lot of new federal rules around insurance as well as creating the marketplaces and QHP rules. Again, Medicaid beneficiaries are often served by multiple programs or can move among programs. We've talked a lot about churn, so that's sort of another piece of the puzzle.

There's a lot of other changes to the landscape. There's been mental health parity rules. There's the essential covered benefits. You know, we don't know exactly how much all of these things are going to be reflected in the new regulation, but they are things that we're keeping an eye on and thinking about.

So, now, I'll walk through -- I'll give you a quick overview of what's in the current reg and then talk about some of the key issues that we think should be on the Commission's horizon.

So, 42 CFR 438 includes nine subparts, which are on the screen. A little bit of context. Prior to the passage of the BBA in 1997 and the promulgation of this original rule, states could only implement a mandatory managed care program through either an 1115 demonstration waiver or through a 1915(b) freedom of choice waiver, and CMS used that waiver review and approval process to put terms and conditions on the states about how they should be operated and what kind of oversight there would be.

When the BBA created the state plan managed care option in which a state could just file a state

plan amendment, it would go through one review, and they could put certain populations into mandatory managed care, this regulation came about to describe what needed to be addressed in that. There needed to be a regulation to support the state plan option. The regulation does apply to all managed care programs -- where states contract with a capitated health plan -- not just a waiver or a state plan. They do apply to everything. But, that was the genesis for this.

Some of the major issues that we expect to be in the new rule and where we think the Commission may want to weigh in are: rate setting, access standards, encounter data, program integrity, and beneficiary protections. So, I'll go over some of the key issues relating to each of these provisions on the following slides.

The proposed reg is obviously going to cover -- it could cover anything on here. It could cover other things. We assume you're not going to want to wait on everything, but when the actual proposed rule comes out, we will look at it and come back to you with the things that we think that you'll be most --

CHAIR ROWLAND: Oh, I am sure there will be every provision that we want to weigh in on.

[Laughter.]

MS. FORBES: This is -- I'm already, like, blocking off my calendar for January and February to deal with this.

CHAIR ROWLAND: The rule will probably only be, what, five or six hundred pages?

MS. FORBES: Oh, I don't really want to think about this.

[Laughter.]

MS. FORBES: This was one of the first jobs I did as a new consultant in the late 1990s, was going section by section, so I'm anticipating a similar -- I'm not an RA anymore, but I'm still going to have to do it.

So, rate setting. We know -- we talked -- Lois and I talked to -- sat down with CMS last year, in the middle of 2013, and talked about this. I mean, they've been working on this for a long time, and CMS has said in public certain things that absolutely will be addressed in the new reg, and rate setting is one of them.

The current regulation requires states to use actuarially sound capitation rates, which means the rates have to be developed in accordance with generally accepted actuarial principles and signed off by a certified actuary, and there's a couple things in the rule about what has to be factored into the rates and how they have to be documented.

There have been sort of questions and concerns raised about this from every quarter. The GAO has questioned CMS oversight of the rate setting process, the staff they use, the quality of the data that states are using to set rates. Health plans and trade associations have actually asked the federal government to make the states be more transparent about their assumptions, particularly around risk adjustment. And, the states have also asked that a new rule take into account things like state maturity and state experience, that states want to take advantage of innovative payment approaches, and so on. So, there are a lot of things that could potentially be addressed in new rules on rate setting. Again, we don't know exactly what

will be in it, but we're sure this will be part of it.

Oh, one other thing I meant to mention. The ACA created a new rule around rate setting, which was to impose a medical loss ratio on commercial insurers, not just to plans in the exchanges but to all commercial insurance. A couple of states apply a medical loss ratio in Medicaid, not many. There's other tools that states use. Chris Park has been following this issue, and again, if that's a piece of the reg, that's something we'll probably want to talk about.

In terms of access standards, the current rule addresses many aspects of access, the major requirement being that states must -- you know, states contract with MCOs and must require that they contract, in turn, with a network of appropriate providers sufficient to cover all of the services that are in the contract. And, there are some other things in the regulation around coordination of care, continuity, authority of services, and so on.

So, we had a session at last month's meeting where some experts came in to talk about some of the challenges associated with measuring and monitoring access to care in a managed care program, and they identified many of the concerns and challenges that are associated with Medicaid managed care standards, including there's the sort of fundamental issue of underlying differences in state capacity, both between states and within specific states. There's uneven application of federal oversight. And, there's a lot of variability in the extent to which states monitor and enforce their own contract standards.

So, CMS has said that the new rule is going to address access standards. We don't know how yet.

There's certainly been advocacy for a much stronger federal role as well as advocacy that the states should have more flexibility to address local conditions, which sort of brings up, I think, one of the overarching policy questions that the Commission will want to think about, which is what is the appropriate balance between sort of -- in a regulation like this, federal regulations applying to a lot of different states -- between having an up-front sort of process and standard requirements versus having more outcome measures and goals.

Should the federal rules provide explicit standards for states to enforce and specific policies that states -- or, processes that states need to execute, or should the regulation set out the goals and leave it up to the states to determine the best way to implement that at the local level? Should the federal rules allow for variation among states, and should that variation take into account things like state maturity, you know, which populations are included, and so on?

So, a challenge CMS will face in developing this new regulation will be where to draw the line between having a consistent and enforceable federal standard and where to allow state flexibility, taking into account that no two state Medicaid programs are the same.

Encounter data -- the current regulation requires that MCOs have to have systems capable of collecting provider and enrollee and service-level encounters and that states have to report those to the federal government. Collection of -- you've heard this from us many times -- collection of timely, accurate, and complete encounter data, it's a longstanding challenge. As long as I've worked in this field, we've

always been talking about how we need to do a better job. MACPAC has noted this in many of our -- in reports where we have a chapter on data. The GAO has raised concerns. OIG has raised concerns. And, it's a legitimate concern.

I mean, if we don't have good encounter data, the states and federal government cannot conduct effective oversight of Medicaid managed care programs. You know, we can't ensure that payments are appropriate. We can't really compare access between different delivery systems or look at how well different interventions work. And, these issues are certainly magnified as more people are enrolled in managed care, as we have more complex populations in managed care, as we put sort of non-acute services in managed care, and as rate setting and risk adjustment systems become more sophisticated.

The ACA provided CMS -- this is one of the few places where there has been a change since 2001. states now have the authority to withhold federal matching funds from states that fail to submit complete encounter data, but CMS has -- I don't know why I said this -- generally been reluctant to impose such a drastic penalty. They have never imposed that penalty. They're never going to.

[Laughter.]

MS. FORBES: I don't know why I said "reluctant." They're not going to do it. It's the nuclear option. I do think what we might see in the reg are some additional sort of intermediate steps that CMS could take to get better data from the plans or from the states.

There are states -- when we did our oversight project -- I mean, some states are doing a very good

job in this area. Some states are doing it because they want to do it in order to implement more sophisticated payment mechanisms. And, some states are more willing to put provisions in their contracts that would have financial penalties, and then to impose those penalties. Those states get better compliance.

So, it is doable and I think we might see in the reg CMS either encouraging or requiring states to take more measures to get those data. We'll have to see what they come back with, but I think that this is a solvable problem. I think CMS is going to be looking for more tools to help get better data.

Program integrity -- the current rule includes a section on program integrity. There's a requirement that MCOs have to have a compliance plan that addresses fraud and abuse. But, the regulation doesn't really specify what plans are really responsible for in terms of program integrity. And, many organizations, including MACPAC, have noted that guidance for states and plans on managed care program integrity certainly lags far behind the state of the art on fee-for-service program integrity. The states have even suggested that CMS should mandate that health plans have to have an annual fraud and abuse compliance plan and go so far as to say the regulations should say what needs to be in that plan.

So, we'll see what they say, but this certainly relates to another overarching issue, which is, you know, we've talked about before, how should oversight responsibility for managed care be divided among the state and federal levels? Many have called for CMS to take a more direct and active oversight role in program integrity, including for CMS to be looking down to the provider level, just as it does on the

fee-for-service side. Others believe that CMS should provide oversight of the states, states should provide oversight of the plans and plans should provide oversight of their capitated providers or their provider networks. So, there are some differences there.

So, one thing -- you know, when we review the proposed rule, we'll have an opportunity to discuss whether the Commission thinks that some of these lines, in terms of oversight, are being drawn in the right place to ensure that there's sufficient oversight, but avoid some of the gaps and duplication that we see with the current set-up.

And, finally, beneficiary protections. The current rule enumerates a number of enrollee rights, you know, prohibiting MCOs from restricting provider-enrollee communications, around how they can market, things like that. There's also a lot of specificity in the rule around enrollee communications, the ID cards, member handbooks, and provider directories, down to the language and the timing and the content and the format. And, to me, I think that rule really reflects where we were in 2001 when managed care was new. There was a very rapid expansion in the late 1990s and there were a lot of concerns about are enrollees going to understand how the system works and how to access the services that they're entitled to.

So, now that, you know, 15 years have gone by, people have more experience. We also have a lot more tools to reach out to beneficiaries. You know, people have access to cell phones and texting and apps and the web, and there are a lot of things. And, there's some sense that the rules, while set up to protect enrollees, may actually be somewhat hamstringing states from taking advantage -- or plans -- from

all of the ways in which you can communicate with enrollees to make sure that they have timely access to the information that they need. So, CMS may make some revisions to sort of better reflect where we are now and to make sure that we're not sort of locking ourselves into a system that doesn't allow change over time.

There are also very detailed rules in the regulation around grievances and appeals. You know, plans are required to have a grievance process, an appeals process, to provide access to hearings. There's a lot of detail around the timing and format of notices and recordkeeping and so on. So, this is an area where the Medicaid rules are very specific and they are also completely unique to Medicaid compared to other payers, which, I think, brings up another overarching issue this Commission is going to want to think about, which is where should Medicaid rules be aligned with the rules for other managed care programs from other payers, particularly QHPs, and where are specific Medicaid rules appropriate?

If Medicaid is in a continuum with the QHPs, or we're looking at duals demos where we're putting folks in plans that are somewhat operating under Medicaid rules and somewhat under Medicare rules, you know, CMS is looking for opportunities. They have said that part of what they're trying to do here is to look for ways to align, and I think grievances might be a place where they try and do that.

I think what the Commission will need to do is look at what's in the regulation and consider, you know, where are the needs of Medicaid enrollees sufficiently unique that a Medicaid rule is appropriate, and where are, you know, operationally, where does it make more sense, because people are moving between

systems or served by multiple systems, to have alignment and help ensure understanding by having a consistent set of rules.

And then, finally, one thing I want to mention in terms of what we're thinking about in terms of managed care, you know, beyond the sort of immediacy of plowing through this reg when it comes out, is, as I said earlier, all state Medicaid managed care programs must comply with these federal rules, but the oversight mechanisms still vary by authority. States operating a program under a state plan option need to submit a state plan amendment. They need to provide assurances that they are in compliance with the rules. It's subject to sort of the regular state plan review by CMS and then they're done. States that are operating under a waiver are required to much more essentially document and demonstrate compliance and then periodically report. And, there is a lot of variation. One thing we learned in our study is there's a lot of differences in the relationship between states and the federal government and what they need to do and what kind of oversight there is.

So, one thing the Commission may want to think about in the future is what are the most effective and appropriate ways for oversight? Are there reasons to have differences among states? Are there reasons to have differences by type of authority? Or, should there be more consistency? So, once the reg is done and out there, we can start thinking about what's the best way to provide oversight of this going forward.

So, as I said, we expect that the proposed reg will be issued early next year. It, hopefully, will have

a 90-day comment period. We'll come back to you when the regulation comes out with a lot more information about what it contains and what it means. But, in the meantime, and the reason we wanted to bring this to you now, is to the extent that you have views on some of these questions that I raised this morning or other things that you think we should be keeping a particular eye out once the reg drops, we'd like to hear about what's important to you so that you can help us think about what a MACPAC response to this proposed reg might look like.

CHAIR ROWLAND: Thank you, Moira, and I think this is really a good opportunity for us to weigh in and give her some guidance on what particular pieces of the reg we may want to look at. And, also, I think one of the issues we'll want to look at specifically is how the Medicare rules interact with or are different from the Medicaid rules, especially given the movement toward integrated systems for the duals. And, I know there are substantial differences at least around some of the grievance and other patient protections between the two programs.

But, others? Trish.

COMMISSIONER RILEY: I think this is really important work, but I wonder if it needs to be in sort of a context. Do we need to first do some kind of an update or summary? There's been so much change in managed care. There's been some movement away from it. I wonder if we need to sort of do a piece, an update, on where we are in Medicaid managed care before -- so we have a framework to look at the regs, because I'm afraid for me, at least, my knowledge is a little bit old in terms of where the field has

gone. And, before we review the impact of regulations, it seems to me it might be better to have a better snapshot in the sense of where the field is.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. We've been looking at what we previously published that's descriptive, and we can provide that as a context piece when we bring this other stuff back. I think the only caution is that some of the data are -- haven't been released. There's not been as many updates as we would have hoped, so -- but, we can certainly bring that back as a refresher, and as we have new Commissioners, I think that will be helpful, so --

CHAIR ROWLAND: Richard.

COMMISSIONER CHAMBERS: Thanks, Moira, for laying out what the agenda is going to be. As Diane, you know, echoing your comment, as one of the health plans that is in the duals demonstration, and you see beneficiaries that are duals in going through the appeals process, is the alignment or the disalignment of, you know, is it a Medicare service they're getting or is it a Medicaid service that they're getting and how it goes off in different appeal trees based on what it is. And, I know CMS is committed to, during the course of the demonstration waivers, is to try to work towards an aligned grievance and appeals process and that's greatly needed, and then as you pointed out, Moira, as transitions between Medicaid plans and QHPs is where, at the local level -- either state by state or at a national level is where if there's alignment, it would be great.

I think as we work through all these issues and look at the new regs coming out in final at some

point in 2015, is that, you know, I think the managed care industry wants to be partners with states and the federal government in providing access to high quality, cost effective care, and hopefully, this Commission can help in making sure that there is a common ground in looking at the perfect, from a regulator or purchaser's viewpoint, as to what it has to be a real partnership with the industry in delivering services and, you know, as Trish said, as the landscape has changed over the last ten or 15 years, but the managed care industry definitely is part of today and into the future in delivery of care, particularly to more complex patients, and I think MACPAC can play a very key role in making sure those standards and oversights in the regs meet the needs of those -- the goals we have for access and payment for Medicaid beneficiaries. So, thanks.

COMMISSIONER COHEN: One area that you didn't touch on, but I think might be worthy of some exploration over the longer term -- and this is a very big issue in New York and, I assume, in some other places, as well -- but, it's the sort of side-by-side development of managed care and these accountable care arrangements, which right now the only sort of formal program at the federal level is Medicare. But, Medicaid is adopting it. And, the issues around how those two models can coexist or work together, but also sort of issues around sending -- this sort of blurring of the lines between the insurance function and the delivery system taking on risks.

So, we're probably at a point where we can really only flag some issues and sort of see what's out there, but that is really the very sort of hot and burning issue on delivery system reform and we want to

make sure that Medicaid is sort of keeping up with the thinking and regulating things in such a way that processes that may be good for beneficiary care and changes in the delivery system are not stifled, but are not, on the other hand, left entirely to market or other forces that may not be the best for them.

COMMISSIONER CHAMBERS: Could I just quickly follow up your comment, Andy? California is going through its renewal of its 1115 waiver, which pretty much the whole program in California runs under, but particularly managed care. And they're looking at changes to it, as the Center for Health Care Strategies at one of the stakeholder meetings recently made a very comprehensive presentation about an analysis and surveys they've done of what states are doing on ACOs and what CMS is approving in state waiver programs and waivers. It was pretty astounding as to how much activity there is at the state level on ACOs, and so it may be helpful to have a presentation or input from CHCS on the work that they're doing.

PARTICIPANT: What was CHCS again?

COMMISSIONER CHAMBERS: Center for Health Care Strategies.

MS. FORBES: Sure, and we'll be coming back to you. Jim and I have been doing these site visits to the states that are doing innovative -- and we've been very struck on those visits about the states that are doing things alongside managed care versus within versus very clearly apart from. And then we have the separate ACO study, so that is definitely something we'll remember to come back and talk about that intersectionality when we come back in the spring on those.

COMMISSIONER HOYT: I'll bring up the data issue again. We've talked about data countless times in the past. I'd be interested in further analysis of where that stands now.

Just to second what Moira said, I know some of the states really do have sanctions in the contracts and that they've been enforced. My impression is they're generally effective, and the reverse is also true. If you don't attach some kind of financial penalty to it, it's more and more difficult to get data.

I think the legitimate frustration on the part of the managed care plans is that they write contracts saying 10 states, 20 states, and the requirements -- you know, the reporting is different. I don't really know how that's evolved now. The programs are a lot more mature, and risk adjustment has driven some improvements in encounter data reporting. But we're still not where we need to be. This may be politically touchy, but I see GAO kind of poked CMS about encounter data. I really think CMS has a central role here to play around the technology of moving encounter data, reporting standards to something that's a little bit more of a consensus because of the frustration that the managed care plans -- which is totally legitimate. This is a solvable problem, like you said, but at least my impression has been nobody is pushing the ball very hard down the field to fix it.

COMMISSIONER CHECKETT: Well, I think it's certainly going to be important, and there will be a tremendous amount of interest in it. Moira, I have a little concern about what the timeline might be, and I know that the proposed regs are published, and we're given a timeline to respond. What do you think that is going to look like? And I'm also wondering just kind of how that will fit with your ability to

turn around and get our input, et cetera.

MS. FORBES: So I hope that they would have a 90-day comment period, not shorter than 90 days. I think that, you know, we've done a lot of work. Anything anyone -- not anything, but I've been trying to collect things that providers, health plans, states, you know, things that have been already submitted in advance of the reg, you know, we have like a master matrix of that feedback, as well as anything CMS has sort of said to signal, as well as a list of issues, and I'll make sure that anything that has come up today we'll add in so, you know, we're ready for when it comes out to start going through it.

There's a lot of us here who have been working on various pieces of this, on payment, on data, on oversight. So I think, you know, we'll be able to split it up. I hope that we would -- depending on when it comes out and our meeting cycle, I'm hoping if it comes out in January, we'll present in February. What we'll probably need to do is even have some suggestions about things to give you something -- not just a summary of the reg but something concrete to react to and then, you know, be able to get that in on time.

If it doesn't come out in January, maybe some of this background, like Trish was asking about more of the context and things like that, maybe we can come back to that earlier, so then we can really focus on the meat of the regulation when it comes out.

COMMISSIONER CHECKETT: Thank you.

COMMISSIONER WALDREN: So two comments, not specifically about the reg, but more something to keep in mind maybe as we're looking at that, but maybe more kind of for the future.

One, the notion about encounter data, I wonder, is that where we need to focus? Is that old data? A lot of people are moving toward outcomes-based quality measurement, and, you know, should we spend all our effort in trying to figure out how do we get good encounter data? Or should we focus our efforts on how do we start getting some quality outcomes data on Medicaid and CHIP patients? So just a question, I think, for us to kind of consider. I think there's challenges, big challenges to the latter, but maybe that's more juice if we want to put a hard squeeze on things.

The others, I think about, you know, managed care, this is a really bad analogy, but it's the closest one I have. It's like saying that, you know, we're doing really bad personally in our finances, so we hire a financial advisor, so, you know, managed care kind of being this financial advisor, but we don't really look at the underlying things of how do we really earn money and how do we actually spend money. Then we decide, oh, well, we need a trustee, somebody that actually also will be financially responsible, so the ACO kind of becomes this financial trustee, a little bit more power, ability to kind of say, no, you can't spend that, but still my underlying kind of habits and behaviors are still doing the same thing.

So I think as we move forward, if we could look at more, I think, on the care delivery side, what's the topology of the care delivery, what's the composition, what are some best practices on process, to get at those things. And I always think about, when Patty talks about what they've done at Denver Health, you know, if we started to look at that and how can we start to propagate that out across the care delivery system, I think that would give us a big thing. That's not a next-year thing, next-five-year thing, but

something to kind of consider and put on our burner for something to think about as we move forward.

COMMISSIONER CHAMBERS: So it's perfect. I was going to say a lot of what you said, Steve. I just want to make the comment that as we look at managed care, it's such a -- back to Trish's comment, how things have changed so much. If we look at it purely as just a financial arrangement between a state and an entity that's going to take financial risk for meeting the standards of delivering care, but below that, as we're so much the innovation, and it's like the service delivery, which is what Steve -- the ACO model, which, you know, has such a structured perspective because of what Medicare has done on their ACOs. But it's really the integrated delivery system with unique financial arrangements and shared savings, which Donna would probably concur as, you know, what all managed care organizations are doing and looking at ways of innovation of having better outcomes and, you know, encounter data and quality and program integrity.

So I just would hope that we would -- if the focus is back to traditional managed care where its dollar is given to an entity that contracts for units of service, the industry has moved past that of looking at what is the real way of delivering high-quality health care and getting the results that we want --

PARTICIPANT: Cost efficient.

COMMISSIONER CHAMBERS: Yeah, always cost-effective, taxpayer dollars. But I hope it's a deeper dive than just the traditional contracts between states and entities.

COMMISSIONER ROSENBAUM: Just a couple of things. One, absolutely to follow on what

Steve and Richard just mentioned, I think that the tenor of our comments as we develop comments and as we develop context is that unlike, say, the network plan arrangements that presumably all of us around this table are members of, when we are talking about Medicaid managed care, we are really talking about the health care delivery system for people, because they do not have discretionary income, and whether they have -- whether they're, you know, sort of traditional beneficiaries who are now bumping up against the qualified health plan system, whether they are dual enrollees, whatever, that we are talking about lower-income people for whom the entire construct has to produce good quality care.

And then the other thing, which was the hallmark of the '98 rule, and I'm hoping remains, you know, an issue in the rules going forward, is the need for all parties -- for states, for plans, for beneficiaries, for providers -- for great clarity as managed care systems are built about what is contractual and what's not, because unlike qualified health plans or Medicare Advantage, in Medicaid managed care states have a really important piece of flexibility which I think they all exercise to some degree or another, and that is, they can choose whether or not to put everything that's in their state plan inside a contract. And if they do that, that's one choice. If they don't do that, then in order to deal with the access and quality questions, there needs to be great clarity for everybody at the table about what's in and what's out. And I think -- and nothing about the Affordable Care Act changes that, at least not for traditional beneficiaries, and even for the newly eligible population, they have certain benefits that are in addition to the essential health benefit package, at least for the moment. So it's got to be clear what's in and what's out.

COMMISSIONER GABOW: Three quick comments.

I think it needs to be clear, as we talk about managed care, what type are we talking about. Are we talking about full-risk contract managed care? And I assume that's generally what we're speaking about, but probably we have to have clarity about that.

One thing I wonder about in these regs or whether it's -- maybe it's something that Richard and Donna can comment about. But as we develop these large data sets, what are the guidelines about data sharing and utilization of the data?

For example, it always seemed difficult to me to share data between our physical health managed care and our behavioral health managed care, even though obviously it would be to the patient's benefit to have every provider have point-of-care data that would be relevant about the patient. But there were many barriers to that data sharing, similarly across school-based clinics, even though they were you're a member and they were getting care at a school-based clinic, they were data from the school you would like to have, like absenteeism, or you would like to be able to tell the school something about this child that's very important. And there were very great firewalls between them.

So I just think that something about what are -- within the privacy protections can we have some guidance that is general so that we're not all negotiating these one-off data-sharing agreements which are really painful.

The last comment I would make is I noticed that you said that managed care companies would like

more transparency about the rate setting. But I think the whole question about financial transparency about the plans, what are they paying different providers? How transparent is all the financial information? Because I think without transparency of quality networks and finance, it's very hard to ever assess what is really going on in the marketplace. And so I don't know how those rules about transparency are going to play out, but if it's just limited to rate setting, that's not going to be adequate, I don't think.

COMMISSIONER RILEY: I would just warn us, when we think about transparency in the market, I'd want transparency for the whole market, the commercial and the Medicaid. Because I think if we find that level of transparency on Medicaid, it doesn't tell us a lot if we don't know how providers are being paid in the commercial side.

COMMISSIONER CHAMBERS: I just wanted to respond to Patty's thing about the whole sharing of data. It's very frustrating. In my experience, we end up with public agencies, particularly on the behavioral health side, or departments like Social Services that deliver personal care services in long-term services and supports waivers and the duals demos. And oftentimes I find as people get much more conservative because I think we've scared everyone into is the fear of releasing any kind of information or sharing data that somebody's going to get in trouble for later. And it's when you're trying to serve, particularly as you're doing patient-focused, you know, delivery of care and you're trying to make sure you're integrating behavioral and dental and long-term services and supports, and, again, as we end up with, you know, public agency lawyers and our company lawyers fighting with each other as to what we can actually

agree to. Again, I think it's more out of fear than it is reality.

COMMISSIONER ROSENBAUM: Well, let me just note what we really need to do is be specific that we want to be sure and comment on the relationship between all of this and Part 2, particularly Part 2, which is, of course, the special privacy rule for substance abuse information, and then, of course, underlying state mental health information. And this area is an area now that's receiving a lot of attention precisely for the reasons you raise.

COMMISSIONER CHECKETT: I know you thought we were nearly finished, but I do just want to make one kind of general comment. It's been a great discussion on managed care, you know, far beyond all the things that I think the rule will actually probably give us an opportunity to comment on. But I do think, you know, one of the things that I like to focus on whenever I stop and say, okay, what are the things that work about the system, what are the things that don't, is, you know, in my mind all of the standards -- and I'll probably be a real pain about this. When it comes to the regulation, I always ask myself, What is Medicaid fee-for-service doing in this area? You know, who is the oversight? What is the role of CMS overseeing the states in their oversight of the fee-for-service system? And, you know, I would love to have an equitable process. And I'm not being facetious about it. I think it's a very genuine, real question that needs to be repeatedly asked, because I have full respect for the decisions that each state makes about what works for them, and what works for their safety net providers, what works for their members, what works for their providers. That's the discretion of the state.

But I think what shouldn't be discretionary is then if a state stays completely fee-for-service, that therefore they can basically be a claims processor. That doesn't work either.

And so I just point that out to the Commission, and I can assure you I'll be raising that question throughout our animated discussion in 2015.

VICE CHAIR SUNDWALL: Could I have one last question?

CHAIR ROWLAND: Okay.

VICE CHAIR SUNDWALL: Sorry. This is a very interesting discussion, and as Donna has just said, it is certainly broader than just the regulation.

My big-picture question is this: With these years of experience we now have in managed care, as contrasted with fee-for-service, how much evidence is there of real cost savings in the aggregate? And I understand, like Patty said, there are different versions of managed care. But is there confidence that this is really saving money? Or is it primarily better outcomes or quality measures? Which I think there is more accountability for. But I'd like to know, as someone who's a taxpayer, is this paying off?

CHAIR ROWLAND: And answer it right now [off microphone].

MS. FORBES: I'll be happy -- I know there have been a lot of studies on that, and there have been some sort of meta analysis of those studies, so we can certainly, when we're coming back with more descriptive information about trends in enrollment and coverage, we can certainly look at some of the research on the outcomes, both financial and other, of managed care. That's probably an important piece

of the discussion.

CHAIR ROWLAND: And I think it goes back to Richard's earlier point that it also depends on how you're paying for managed care. It's not just whether it's -- it's in comparison to fee-for-service, but it's also really looking at the basic payment rates, the risk adjustments, and all the other pieces. And so whether that's in the reg or not in the reg, I think Donna has put it on the table, Richard has put it on the table; it's part of what we should be looking at.

So just really have a great holiday, Moira, because in January you'll be back with a lot of new answers for us.

At this point, if there are any comments from the public, we would like to entertain them.

PUBLIC COMMENT

* [No response.]

REVIEW OF PRIOR DAY'S DISCUSSION

* CHAIR ROWLAND: Okay. Well, I think at this point we have come to the conclusion of our December meeting, but we've also come to the conclusion of the terms of one-third of our founding Commission members. We've worked together over the last five years to establish this group, to hire the terrific staff that we have and Anne as our Executive Director to shape our work so far over the last five years and to prepare really for the next years. We'll have a new generation of Commission members, but I wanted to once again on behalf of all the other Commission members and the staff thank those of you who

will be leaving us after today, who have uniquely contributed and shaped what we are:

Richard Chambers, as I said, your experience at HCFA, your on-the-ground view from California, which you expressed so well today, have continued to inform us and help shape the scope and quality of our work.

VICE CHAIR SUNDWALL: Denise.

CHAIR ROWLAND: Denise Henning, an advocate for pregnant women you have cared for, and your passion for pregnant women and midwifery will be with us as you run out the door.

[Laughter.]

CHAIR ROWLAND: Judy Moore, you brought us years as a federal government employee, the history of Medicaid, how it has evolved, every discussion, and continue -- and we'll continue to ground our debates with your knowledge and your experience.

And, Burt, you leave behind as a permanent MACPAC principle that the mouth is part of the body and that dental access has got to be put into everything we do and remain a top priority, and so we will hear you throughout the coming years, I know. You have left the dental mark. Your teeth are on us.

And to Robin Smith, who is not with us now, she was our Mom and the voice of our beneficiaries who always saw the program from its most important perspective, how does it work for those who need it the most, and that principle, too, I think will be with us now that Robin will be leaving the Commission and joined by someone else.

And then there's David Sundwall, our Vice Chair. His Hill and state experience helped frame our role, who reminds us always that there is public health and a public health role and population health for Medicaid beyond just the financing and paying for medical care; and who has also kept us always on the straight and narrow road to establishing nonpartisan credibility and reminded us about the fact that everything doesn't happen on the east coast, there are places like Utah that we have to remember. And, David, I want to especially thank you for the strength you've given us and your tremendous role as our Vice Chair.

And we'll miss all of you, but you will always be part of our MACPAC family. Thank you.

VICE CHAIR SUNDWALL: Thank you.

[Applause.]

CHAIR ROWLAND: And on that note, happy holidays to everyone, even to the staff who we've given a lot more work to do right now, and to all of you who joined us today, I hope the holiday season turns out well, and thank you again to all of our Commissioners.

We're adjourned.

* [Whereupon, at 11:09 a.m., the meeting was adjourned.]