PUBLIC MEETING

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

Thursday, December 10, 2015
10:10 a.m.

COMMISSIONERS PRESENT:

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MARSHA GOLD, ScD, Vice Chair
SHARON L. CARTE, MHS
DONNA CHECKETT, MPA, MSW
ANDREA COHEN, JD
PATRICIA GABOW, MD
HERMAN GRAY, MD, MBA
MARK HOYT, FSA, MAAA
NORMA MARTÍNEZ ROGERS, PhD, RN, FAAN
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
PATRICIA RILEY, MS
SARA ROSENBAUM, JD
PETER SZILAGYI, MD, MPH
STEVEN WALDREN, MD, MS

ANNE L. SCHWARTZ, PhD, Executive Director

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

2 [10:10 a.m.]

3 ### Updates on Commission Activities

4 * CHAIR ROWLAND: Okay. If we could please convene
5 for this meeting of the Medicaid and CHIP Payment and
6 Access Commission. Our December meeting is the last
7 meeting of 2015, and also I would recognize that it may
8 well be the last meeting for one-third of our Commission
9 members who have served with us since 2009 when appointed
10 and 2010 when the Commission received adequate
11 appropriations so that it could actually begin to meet.

12 So I want to start this meeting by thanking the
13 service of all of my colleagues who have been with us since
14 the very beginning, and to also thank those who joined us
15 last January for filling in and fitting in and adding so
16 much to the work of this Commission.

17 And I also wanted to thank the staff for what I
18 think is really one of our best contributions referred to
19 as the "Medicaid Bible" or "MACStats: Medicaid and CHIP
20 Data Book," and especially to April, who really helped put
21 this together and helped put our data together. But
22 MACStats I think has become one of the signature features

1 of our work and really I think the shift to having an
2 annual data book instead of just putting segments into our
3 March and June reports, but keeping the data also on the
4 website so that it could be refreshed and updated
5 throughout the year will make this a very useful and
6 important contribution as people try to base Medicaid
7 decisions on facts and analysis rather than on suppositions
8 of what may or may not be going on.
9 And with that, I'm going to turn to Anne for any
10 other updates of the Commission's activities, and then we
11 will move on. You have testified since our last meeting.
12 EXECUTIVE DIRECTOR SCHWARTZ: Yes, we testified
13 in the Energy and Commerce Committee on supplemental
14 payments and data reporting, which was very handy to have
15 that follow after the October meeting when you had come to
16 a recommendation on reporting of payments.
17 We actually just got the questions for the record
18 for that this week, and they're on another bill that very
19 little was said at that meeting about, so we'll respond to
20 those and get those back to you.
21 Also just to let folks know that our next
22 iteration of the data book on dually eligible individuals

1 that we have been doing jointly with MedPAC will be coming
2 out in January.
3 CHAIR ROWLAND: And the report due to Congress in
4 February on disproportionate share hospital payments, the
5 first of what will be many that this Commission is required
6 by Congress to assess and produce, will be included in our
7 March report and available on February 1st, the deadline,
8 electronically. So that we have now wrapped up our work on
9 that and are now moving forward to our agenda for today,
10 and that includes beginning with an update from the staff
11 on the access to care issues in Medicaid and especially the
12 reg that just came out. So I am going to turn to Tab 1 for
13 the Commission members and to Anna Sommers.
14 **### Access to Care in Medicaid: Review of Final Equal**
15 **Access Rule**
16 * DR. SOMMERS: Good morning. On November 2nd, CMS
17 published the final rule on the equal access provision with
18 a 60-day comment period. This provision requires that
19 state Medicaid provider payments be consistent with
20 efficiency, economy, and quality of care and sufficient to
21 enlist enough providers so that care and services are
22 available under the plan, at least to the extent that such

1 care and services are available to the general population
2 in the geographic area.
3 This presentation will review key provisions and
4 major changes in the language from the proposed rule, which
5 was published over four years ago and prompted extensive
6 comments from stakeholders. MACPAC submitted comments on
7 the proposed language at that time.
8 In conjunction with the final rule, CMS also
9 issued a Request for Information to obtain public input
10 into additional approaches to the access requirement for
11 CMS to consider, so we will also summarize that for you.
12 The comment period on both the final rule and the RFI ends
13 January 4, 2016, when the rule becomes effective.
14 This is the first regulatory guidance on the
15 equal access provision. Until recently, enforcement of
16 this provision has typically fallen to beneficiaries and
17 providers through a private right of action through the
18 courts, but this mechanism did not lead to clear standards
19 or a clear process for states to assure compliance with the
20 law.
21 The recent Supreme Court decision, Armstrong v.
22 Exceptional Child Center, removed the provider's private

1 right of action to enforce the equal access requirement.
2 Still, over 40 percent of enrollees still receive some or
3 all services under fee-for-service payment, and these
4 individuals often are high-risk, high-need individuals.
5 In the absence of any consensus around standards
6 to define access, the final rule instead focuses on
7 establishing a data-driven framework and process for states
8 to document payment adequacy and access to care.
9 Scope of the access rule. The access rule
10 applies to services and payments for these services made
11 available under the state plan through fee-for-service
12 payment, including the authorities listed on the slide.
13 The rule does not apply to capitated payment to Medicaid
14 managed care, which was addressed by the proposed rule
15 published in May. Nor does it apply to waiver or
16 demonstration programs.
17 The key provisions of the rule follow two key
18 principles: documentation and transparency of state
19 process. States will now be required to develop a medical
20 assistance access monitoring review plan that demonstrates
21 sufficient access to care in fee-for-service Medicaid and
22 to update the plan periodically.

1 Several new provisions address state process for
2 developing and updating the plan, required content of the
3 plan, and submission requirements to CMS. The rule also
4 enhances transparency of state processes in its access
5 monitoring activities by enhancing requirements for public
6 and provider input and by adding public notice
7 requirements.
8 Final language of the rule reserves flexibility
9 for states to select and define its own measures and
10 approach to reviewing access in fee-for-service Medicaid,
11 but requires states to document their approach in the
12 review plan, and they must spell out their choice of data
13 sources, measures and methods, report the baseline and
14 trend data in the analysis, and analyze access for each
15 geographic area, to be defined by the state. And, in
16 addition, states must report any access issues discovered
17 during the review.
18 The review plan analysis must measure all the
19 factors listed on the slide here and then tie this evidence
20 to the conclusions and recommendations it makes about
21 sufficiency of care. So under characteristics of the
22 beneficiary population, which is the fourth bullet on the

1 slide, the final language added that states must consider
2 care, service, and payment variations for pediatric and
3 adult populations and individuals with disabilities.
4 Finally, the states are required to include a
5 comparison of Medicaid payment levels relative to payment
6 by public and private payers for each provider type and
7 site of service. However, states may choose the public and
8 private data sources that they will draw on.
9 States are required to submit their first review
10 plan to CMS by July 1, 2016. The plan must include review
11 of five core types of service and update this review plan
12 every three years. Review of other services would be
13 triggered under two circumstances. Review would be
14 required prior to submission of a state plan amendment that
15 proposes to reduce payment rates or restructure payments
16 for a service in a way that would result in diminished
17 access to care. In this case, states are then subject to
18 additional review and reporting requirements for these SPA
19 submissions.
20 The final rule includes the additional
21 requirement that states must review access for a service if
22 states or CMS receives a significantly higher than usual

1 volume of complaints about access to a service in a
2 particular geographic area. When either of these two
3 conditions arises, the state must add the affected services
4 to the access monitoring review plan and monitor access
5 levels for a minimum of three years.
6 Listed on this slide are the five core types of
7 service subject to review: primary care services,
8 including dental care and FQHC services; physician
9 specialist services; behavioral health, including mental
10 health and substance abuse disorders; prenatal and
11 postnatal obstetric services, including labor and delivery;
12 and home health.
13 This is a change from the proposed rule which
14 required review of all covered services every five years.
15 CMS selected these services over others because of their
16 high utilization by Medicaid beneficiaries and because they
17 represent primary access points for all other services.
18 Final language enhanced requirements that were
19 part of the proposed rule to ensure that states incorporate
20 public input into the development of the access monitoring
21 review plan and to consider feedback from beneficiaries and
22 providers through a variety of mechanisms that are listed

1 on the slide.

2 The rule enhances protections for beneficiaries
3 experiencing access problems by requiring states to
4 maintain a record of complaints, respond promptly to them
5 and make a record of those responses, and by adding a time
6 frame of 12 months for corrective action to take place when
7 a deficiency is identified.

8 So as I have mentioned throughout the
9 presentation, the final rule makes some major modifications
10 from the proposed rule in an effort to minimize state
11 administrative burden, but enhance protections for
12 beneficiaries and providers when access could be at risk.

13 As I mentioned before, the final rule limits the
14 services subject to periodic review and requires updates
15 every three years rather than five. The proposed rule
16 required states to review a subset of services at each
17 annual review in order to evaluate all services every five
18 years, and this requirement was removed in the final
19 language. Instead, annual review of a service is only
20 triggered when states receive a high volume of complaints
21 or a deficiency is identified during a review.

22 The SPA submissions under the final rule must

1 include an access review only if they are limited to
2 payment changes that -- the SPA submissions that require a
3 review are limited to payment changes that result in
4 diminished access.
5 The final rule also clarifies what CMS considers
6 to be minimum supporting documentation with the SPA
7 submission and their criteria for disapproving a SPA.
8 And, finally, it added requirements for public
9 notice prior to submission of a review plan to CMS,
10 accessibility of websites if used for public notice,
11 provider input, and maintenance of records about the volume
12 and nature of state responses to beneficiary feedback and
13 complaints.
14 MACPAC's comments to the proposed rule appear to
15 be largely addressed in the final rule. Concerns that
16 Commissioners raised about improving federal data fall
17 under the scope of the request for information, which I
18 will cover next.
19 CMS acknowledges that the development of a
20 framework for meeting its own obligations under the equal
21 access provision and helping states to meet their
22 obligation is going to be an ongoing process. Establishing

1 standards for access to care is not feasible today because
2 there is no consensus about what those standards should be,
3 and CMS recognizes that it may not be practical or
4 desirable to have federal standards. Nonetheless, CMS
5 seeks feedback on whether or not it should establish a core
6 set of measures that all states would collect, what
7 measures should those be, who should collect them, and how
8 the measures would be employed in the regulatory process.
9 Should there be a universal threshold or goals? And if so,
10 how should CMS and states use them in the monitoring
11 process and in the complaint and remediation process?
12 That concludes our review of the access rule.
13 We also want to make you aware of some related
14 work. MACPAC is reviewing proposals now to examine how
15 states currently monitor access to services under fee-for-
16 service Medicaid. The major tasks under this contract will
17 be to scan state program documentation of regulations, data
18 sources, and measures, survey state Medicaid agencies on
19 current access monitoring activities and fee-for-service
20 programs, and produce a summary report and state-by-state
21 catalog of the features of state access monitoring
22 practices. We expect to have results by summer of 2016,

1 which will provide a richer understanding of current
2 practices and the level of effort states are undertaking to
3 meet the new requirements.
4 Along with access monitoring plans due to CMS
5 next July, results can be used to identify common measures
6 and methods and areas where states could be helped by
7 federal data collection or measurement development.
8 That concludes my presentation and we look
9 forward to your questions.
10 COMMISSIONER ROSENBAUM: Thank you, Anna. I have
11 several observations about the rule. The first is, I
12 wonder if we could spend that -- not time now, but in
13 thinking about this rule, spending time sort of working up
14 some cases, meaning case illustrations, to give people a
15 sense of, in a range of different kinds of states, exactly
16 what services would be covered by this rule, because in a
17 state where the vast majority of the patients are in
18 managed care, and where people who need long-term services
19 and supports are in various kinds of long-term services and
20 supports demonstration arrangements, I think I think
21 this is an extremely limited rule and I think it's
22 important for the Commission to make clear the limits of

1 the rule. We could have states that are virtually
2 untouched by this rule, except for some very, very limited
3 carved-out services.
4 A second observation is that, ironically, one of the
5 driving forces in a lot of litigation that's gone on, that
6 ultimately led to Armstrong, is payment for the most
7 advanced disability cases, children and adults who are in
8 long-term institutions. They are not in home and
9 community-based services and support programs. They have
10 such extensive disabilities that, for better or worse, they
11 are being cared for in an institutional setting. And one
12 of the monitoring elements in the rule is not the long-term
13 institutional placements that have been the subject for
14 some litigation. So we're monitoring obstetrical services,
15 which is great because it's obstetrical services, but let's
16 face it, most obstetrical care is in managed care now.
17 We're monitoring pediatrics but most ambulatory pediatric
18 care is in managed care now.
19 And so I'm not clear as to the logic of CMS's own
20 thinking about the measures that it's collecting data on,
21 because they are not necessarily the measures that lend
22 themselves to fee-for-service monitoring. A lot of those

1 measures relate to services that are now bundled up in
2 managed care payments.
3 And the only other point I would make is that
4 many places the agency has served, that there is no
5 consensus about access, about how to appropriately measure
6 access, and I certainly know that on the granular level
7 that is true, that some people say an urgent care visit
8 should happen in 24 hours, some people say 2 days,
9 whatever. But I guess I am still puzzled by why it's not
10 possible to take the range of measured used in various
11 settings and suggest ranges to states. I mean, you know,
12 an emergency visit, we know, should happen immediately, but
13 we also, I think, looking at measures that states use, and
14 especially in managed care but certainly measures that
15 integrated delivery systems like Kaiser use, there are
16 measures, and I guess I'm not clear as to why CMS is not
17 offering ranges, why it was so insistent that it could
18 offer no guidance at all.
19 And I have to say the irony in that is that while
20 you are correct that there will not be litigation by
21 providers against states, because of Armstrong, there may
22 well be litigation by providers against CMS for approval of

1 changes in payment that impair access, and if CMS has not
2 done anything to shape the evidence on which its approval
3 rests, other than to say to states, "Give us your evidence
4 so that we can see what you were thinking about," I don't
5 see that the agency is any less subject to challenges than
6 it was before. So even if you take the narrow legal
7 holistic view of this rule, it doesn't seem to really do
8 much.
9 So I guess I'm mostly concerned about how they
10 selected which measures they do want data on, also their
11 assertion that there really are no measurement ranges to be
12 offered, and, you know, whether this gets them the kind of
13 evidence base that they, themselves, are going to need,
14 given the Armstrong decision.
15 CHAIR ROWLAND: But underlying your comments
16 where you began, I think one of the pieces that this
17 Commission could contribute is who's remaining in fee-for-
18 service.
19 COMMISSIONER ROSENBAUM: Absolutely.
20 CHAIR ROWLAND: We know, who are these 40 percent
21 of the population, what are their health needs, how many of
22 them are in institutions? I think it's fairly hard to do,

1 but I think it could be something that our data mavens
2 could work on.
3 Chuck, who is next.
4 COMMISSIONER MILLIGAN: I wanted maybe to come at
5 it from a different direction. The statute that this
6 relies on, the Social Security Act statute, and I don't
7 remember the exact language, but it's something like access
8 comparable to the general public or general population, and
9 when I was in Medicaid on the state side, it was never
10 clear to me what that meant, because as more and more
11 providers chose not to have Medicare contracts, as more and
12 more commercial plans went to high deductibles, as more and
13 more boutique medicine happened, it wasn't clear to me what
14 we were comparing ourselves to.
15 And so I guess one of my theories, to Sara's
16 comments, is that these categories seem to be the most
17 comparable to other forms of insurance as opposed to DD
18 waivers or something. But it still isn't clear to me what
19 the comparison is, because if you try to find a dentist
20 with commercial insurance it's difficult.
21 So I guess the question I would ask is whether
22 there's any illumination from a Social Security Act

1 framework, about what it is a Medicaid agency should be
2 comparing itself to, in terms of adequacy of access and
3 network and, you know, appointment times or whatever,
4 because it's a little bit of like the sound of one hand
5 clapping to me.
6 So any insights into that?
7 COMMISSIONER ROSENBAUM: I would just note that
8 the statute, the etiology of the statute is that its first
9 iteration appeared in the Handbook of Public Administration
10 Supplement D, so 1966.
11 [Laughter.]
12 COMMISSIONER ROSENBAUM: That's true. This is a
13 very strange statute. It then ultimately made its way
14 through a rule, and then in 1989, Congress picked it up and
15 put it into the statute. And you're absolutely correct
16 that it came along. I mean, in 1966, we were all about
17 mainstreaming and we were going to have a payment program
18 for poor people that looked just like insurance payments
19 for others, and the problem, as you, I think, correctly
20 note, is that we have now diverged.
21 And so, in fact, to me, the more important part
22 of the statute is not the Equal Access, as it's known, the

1 Equal Access Statute, but is the requirement that payments
2 be consistent with efficiency and quality, and equal. So
3 if we put aside the equal part and just said, are you
4 running an efficient program, that, I think, gives CMS the
5 authority to ask questions about access, but I think more
6 guidance is needed than what they've done here.
7 COMMISSIONER COHEN: I mean, I don't want to beat
8 the dead horse, but from the summary -- and I haven't read
9 the real thing -- it sounds like there is not one sort of
10 objective standard anywhere in the rule, and it's very -- I
11 mean, it's a very, give us some evidence and we will look
12 at it, we compare it to what we have. I mean, nobody has
13 any idea of what the standard would be for review or
14 anything else either. Is that right that there is
15 literally no -- there's just no standard anywhere to say
16 what is the threshold for CMS to take action or say that
17 something is not acceptable? It's like, not in terms
18 maybe in terms of process only but not remotely in terms of
19 results. Is that right? Is that right, because that's
20 what the summary sounds like.
21 MS. SOMMERS: Yeah, and they make that very clear
22 in the preamble that there is no -- they are setting no

1 federal standard.

2 COMMISSIONER COHEN: Yeah. So, I mean, to me --

3 CHAIR ROWLAND: And Andy, as you might recall, we
4 struggled with this very issue on developing an early
5 warning system, and the fact that we could not also come up
6 with, if you cross this threshold all bells and whistles
7 ought to go off if there's a problem.

8 COMMISSIONER COHEN: Yeah, but -- yeah, we are a
9 17-member, you know, commission and not an administrative
10 agency. Anyway, I mean -- so I know it's a really
11 challenging area but like Sara, I guess I think there's
12 lots of ways to provide some framework around an area where
13 precision or a standard threshold or something like that is
14 not appropriate, which I would say is the case here, and I
15 just feel like there are some I would propose that we
16 say something about just to me, it's like not a very
17 it's not a wise governing framework for a 57, you know,
18 jurisdiction program, or maybe it only applies to the 51
19 states. I'm not sure. But, you know, it's just -- it's
20 not -- it's not a good framework for managing a program
21 like this to say "I'll know it when I see it," which is
22 effectively what this rule is saying. So I --

1 CHAIR ROWLAND: And some safety zone.

2 COMMISSIONER COHEN: Yeah. Exactly. Exactly.

3 [Simultaneous discussion.]

4 CHAIR ROWLAND: -- presume it's a -- that you're

5 --

6 COMMISSIONER COHEN: Right. Exactly. There's so

7 many there are many, many regulatory options to deal

8 with. We can't set a number and say everybody has to meet

9 it. There's lot of options, and I just -- I -- my personal

10 perspective is --

11 CHAIR ROWLAND: I think, Andy, that's a little

12 unfair. I mean, I do remember that when we started this

13 process, and we started our comments and the Administration

14 actually picked up on the framework that MACPAC had to

15 developed, which had a lot of places where you could

16 establish criteria, and one of the issues that the states

17 and other people went crazy about was that those criteria,

18 or those issues to look at were not well-defined.

19 So I think one of the struggles, and the reason

20 there's this request for information, is to try and figure

21 out what standards one would have and how to get to them,

22 so that clearly this reg, I think, went a little

1 backward from the one that was originally proposed. It was
2 strengthened in some places but trying to reduce the
3 administrative burden. But I think the bigger issue here
4 is how do you end up getting value and efficiency and
5 adequate access, and I think we're still struggling with
6 what those measures are.
7 COMMISSIONER COHEN: So can I just ask one
8 clarifying question? So this is -- what's the --
9 CHAIR ROWLAND: This is a final rule.
10 COMMISSIONER COHEN: Right. So it's a final -- I
11 understand that they are saying more work needs to be done,
12 but it is a final rule. So, you know, I respectfully sort
13 of disagree. I think it would be appropriate for MACPAC
14 and, of course, that's only if we agree, but to, in some
15 way, express that for a final rule it is really missing,
16 sort of, any objective, sort of, criteria, and that I think
17 that's not -- it's not a good approach to regulating this
18 program. I'm not saying it's easy. This is not a blame
19 thing or that it's an easy program to regulate or an easy
20 area to pick a standard. I just -- I think it's a bit,
21 sort of disappointing approach.
22 CHAIR ROWLAND: I have Mark, and I have Patty,

1 and then I have Trish.

2 COMMISSIONER HOYT: I had a couple of higher-

3 level comments or questions and then a couple of specifics.

4 So in the material that was distributed

5 beforehand that I read through, first, the way it was

6 reading to me was, wow, this is going to be pretty

7 complicated to come up with all this. And then I hit the

8 estimated costs that were provided by state, which were

9 shockingly low to me, with real specific dollar amounts.

10 Where did those costs come from? I mean, what's the

11 anticipated level of effort required to comply?

12 DR. SOMMERS: Well, they state that they

13 estimated that it would cost about $22,000, $22,600 per

14 state to develop their access monitoring review plan,

15 another $22,600 to do the update. The total cost across

16 states comes to about $2.15 million.

17 EXECUTIVE DIRECTOR SCHWARTZ: But, Mark, I think

18 you are correct. There are very specific numbers for the

19 very specific elements, but there's not a lot there for us

20 to help enlighten where those numbers came from.

21 COMMISSIONER HOYT: Okay. So it got me to

22 thinking. I don't know, many states, most states, if

1 they're doing managed care contracting, I think they
2 probably -- a lot of them that I've seen address this issue
3 in a scoring criteria area pay to managed care, where you
4 would try to define -- or score something, telling you
5 something about access to the different networks. I know
6 there's a different reg about this, but to me it just
7 begged the question, why are there two regs? Isn't access
8 to care just access to care? It's not immediately clear to
9 me why you would have a different set of standards or
10 compliance effort behind managed care than you would fee-
11 for-service. Then if you go that way, it seems like you
12 are faced with a possibility of, well, then, managed care's
13 going to be held to a higher standard than the state is
14 fee-for-service, why would you do that? Or it's going to
15 be a lower standard where they can't even meet the fee-for-
16 service standards, in which case why are you doing managed
17 care? So that just stirred up a bunch of questions for me.
18 A last comment, and then I'll back away, is on
19 the comments about provider payment. I'm looking here at
20 Slide 7, actual or estimated levels of provider payment, at
21 least in my mind, are impossible, would go nowhere. If you
22 could get data on what employers or others pay providers,

1 you know, it would be all over the map. Even if you had
2 data, say, on -- I don't know -- pediatrics, to just pick
3 an area, then you've got all these different codes and
4 visits. What if they're low in some, high in others? How
5 do you weight all those together? I don't know how you're
6 going to draw any conclusions or what they're anticipating
7 somebody doing, evaluating provider payment. And then it
8 didn't seem like they mentioned Medicare, which would be
9 something you could go to to compare. So, you know, if you
10 had any thoughts on that.
11 COMMISSIONER GABOW: Sort of to pick up on Mark's
12 managed care, I think it would be useful to create a side-
13 by-side comparison of what are the access criteria that are
14 in the managed care regs and the outcome quality, what
15 service, whatever access that you're going to do, and then
16 this rule, which appears to have blanks, and part of it may
17 be, as you were saying, Diane, who's covered in each of
18 these bins. And it may be that when you look at what
19 managed care has and who's covered that it does become a
20 barrier, that you can't use the same standards because the
21 populations are completely different. I think that would
22 be a very -- the comparisons side by side and the

1 populations side by side would give us something to say
2 about where to go, I think.
3 I have two other comments. One is the physician
4 specialists that you listed, you have examples, but did
5 they pick those specialists like out of a hat? Because for
6 adults and children, they may be quite different who you
7 would want. I mean, kids' asthma is going to be one of the
8 big issues, so if they go to any specialists, it would
9 probably be a pulmonary person, most likely. But I think -
10 - are the specialists defined, is a question.
11 And my last comment is I think one of the
12 criteria on that tells you about adequacy of access is the
13 downstream implications of failure of access. So, for
14 example, I've said this -- and, again, I'll perseverate on
15 a few issues in my last meeting. The procedures that --
16 CHAIR ROWLAND: We wouldn't want it any other
17 way.
18 COMMISSIONER GABOW: I know. The procedures that
19 come out of seeing a specialist are -- because you have
20 procedure codes, and I think I sent Anne something recently
21 about it, divergent issue in procedures, and so, you know,
22 if someone isn't getting hernia surgery, someone isn't

1 getting, you know, whatever for that population, genetic
2 testing for OB, I mean, there are some procedure things
3 that reflect adequacy of the access that maybe should be
4 put in. So that's one downstream effect, is procedure.
5 The second downstream effect is complication.
6 So, for example, if you are having a high percentage of
7 adults -- well, adults probably don't apply -- children
8 with abscesses who require removal of a tooth or kids like
9 we saw that had bombed out mouths and the entire -- they
10 had to go under general anesthesia to have all their teeth
11 removed, that outcome is a failure of access to dental
12 care. I mean, there are other issues.
13 If you look at the data on stage of breast
14 cancer, then you say, well, that probably reflects
15 inadequate screening or primary care. If you look at the
16 incidence of suicide, that may be a downstream factor in
17 adequacy of mental health and substance abuse care.
18 So I think -- and in some ways that's easier data
19 to get some of that, and so I think thinking about the
20 downstream problems from inadequacy as a reflection of a
21 problem, that could trigger an alarm bell. You say, well,
22 what could trigger an alarm bell? It seems to me that some

1 of those -- and none of them are perfectly clean. I mean,
2 you can say, well, a bombed out mouth, that has to do with,
3 you know, holding a bottle in a baby's mouth all the time,
4 and so it's not just adequacy of care, and suicide is
5 complex, but at least we know they're linked in some way to
6 inadequate intervention. So I think giving some thought to
7 that may have some utility about alarm bells. And it's one
8 of our early --
9 CHAIR ROWLAND: Early warning system. Okay.
10 COMMISSIONER RILEY: I share the concerns about
11 the limits here and the need to have -- access is access.
12 It's fundamental and it ought to be across platforms. But
13 it strikes me that it also is in an environment of payment
14 reform where there is such change about the field that it
15 has to reflect some of those changes, and I think it
16 doesn't. It feels kind of yesterday's news in some ways.
17 But it also strikes me that it's such a
18 fundamental for this Commission and such a fundamental of
19 Medicaid, and it's so difficult to do, and HHS really can't
20 engage stakeholders in a rulemaking process, that it might
21 be an appropriate role for the Commission to think about a
22 work group that brings the stakeholders together. Because

1 the way this issue has evolved, it's through the courts.
2 You know, providers want more money, Medicaid can't pay any
3 more, and the consumers are sort of the volley ball in the
4 middle. And it strikes me that if you could get a real
5 working group to think about what would three core measures
6 be that would -- or one that would adequately measure
7 access across platforms, that would relate to payment
8 reform, and the players together would work with HHS, it
9 strikes me that that could be a value-added that the
10 Commission could bring to a debate that just keeps going on
11 and on.
12 CHAIR ROWLAND: I think that could be very
13 valuable. I also think that that is a good transition to
14 the next part of this discussion where Amy is going to both
15 fill us in on some of the work underway here at MACPAC.
16 Tomorrow you'll be going to the convening that the federal
17 government is having around data and performance standards
18 for access, correct? So you might also tell the Commission
19 a little bit about what that meeting is tomorrow.
20 VICE CHAIR GOLD: Diane, I know you want to move
21 us on, but I wonder --
22 CHAIR ROWLAND: We're moving on to just access.

1 VICE CHAIR GOLD: Okay. Well, I was thinking of
2 -- I had a suggestion for how we might approach a letter to
3 HHS that reflected some of these concerns from a forward-
4 looking perspective. And I didn't know if this was the
5 time to raise --
6 CHAIR ROWLAND: Well, let's go through Amy's
7 presentation of what we have underway.
8 VICE CHAIR GOLD: Okay.
9 CHAIR ROWLAND: Which might help inform what we
10 would say in a letter.
11 VICE CHAIR GOLD: Okay.
12 **### Access to Care in Medicaid: Access Work in**
13 **Development**
14 * DR. BERNSTEIN: Thank you. So having now said
15 that it's really hard to assess access and to look at
16 differences between Medicaid and private, we're going to
17 show you some data on different --
18 CHAIR ROWLAND: Do you have your mic on fully?
19 DR. BERNSTEIN: I do. Maybe I'm not doing it
20 right.
21 I'm going to tell you about a couple different
22 things that we have going. As I said, we have a new report

1 series that we're calling Medicaid Access in Brief, which
2 does, in fact, compare Medicaid and private insurance, and
3 on specific access measures.
4 We also are starting some really exciting
5 provider supply analyses, and I'm going to tell you about a
6 couple contracted studies that are ongoing.
7 So on our Medicaid Access in Brief publications,
8 the idea behind these was to expand upon what's already in
9 MACStats. MACStats and your data bible that you all have
10 looked at now have many tables using national survey data
11 that look at the demographics and utilization and access
12 experience that compare Medicaid sort of as a group to
13 private and uninsured as a group.
14 One thing that has come up in several of your
15 discussions is that it would be nice to have a little more
16 granular data to look at sort of subgroups of Medicaid
17 compared to subgroups of private. So, on average, private
18 insured people have higher incomes than Medicaid, so it
19 would be nice to compare sort of low-income to low-income
20 rather than the lower-income Medicaid to the higher-income,
21 on average, private.
22 So these little reports -- they're about six to

1 eight pages, is our hope -- focus on comparing Medicaid,
2 privately insured, and uninsured, and they focus on one or
3 a few measures that are sort of one topic. So I'll show
4 you examples in a minute of sort of what the groupings are.
5 And then for each of these reports, we stratify and present
6 data by each of the measures by the appropriate age groups,
7 by race and ethnicity, by poverty level, and by disability
8 or special health care need status, so we're comparing sort
9 of like groups to like groups. And we also discuss trends
10 when possible, and I'm going to talk about some limitations
11 of the data in --
12 CHAIR ROWLAND: Amy, in any of this analysis, is
13 there any way to distinguish between those in fee-for-
14 service and those in managed care?
15 DR. BERNSTEIN: No, because it's survey data, so
16 that's one of the limitations. Survey data is very blunt
17 force for the most part.
18 VICE CHAIR GOLD: Amy, some of the CAHPS stuff
19 may let you do that.
20 DR. BERNSTEIN: But then we would have to compare
21 Medicaid to private, so we need something that compares
22 those two.

1 COMMISSIONER RETCHIN: Could you at least look at
2 the managed care penetration level by geography to see if
3 there was a trend?
4 DR. BERNSTEIN: No, because we would have to
5 merge it with the survey data, and we do not know sort of
6 where the people are. We don't have state-level data, and
7 for most of these surveys you can't even do state-level
8 analyses, unfortunately. Very blunt, brute force, which is
9 really unfortunate for a variety of reasons.
10 So our first set of reports that are almost done
11 and we're hoping they will come out soon, in January or
12 maybe early February, focused on children age 0 to 18,
13 because that's what the surveys ask. It could have been
14 21, but surveys consider children 0 to 17 or 18. And the
15 four reports that are coming out first are one with
16 difficulties obtaining medical care: Did you have trouble
17 accessing certain things for different reasons? Oral
18 health, behavioral health, and emergency department use,
19 and access. Then we're going to move on to non-elderly
20 adults and then in the future add other groups -- elderly,
21 whatever, mental health, whatever else we have national and
22 comparable data on. And some of the constraints that you

1 have all raised is we would all like to see everything
2 crossed by everything, and we would, too.
3 But the first major limitation is these are
4 survey data. They are respondent-reported, and it has been
5 shown in various presentations that we've given that when
6 you use different surveys, you can get different results
7 for things like number of visits because they are self-
8 reported. However, the trends and the differences between
9 groups tend to be pretty stable. The levels tend to differ
10 some.
11 The main problem is with sample sizes. So when
12 you're looking at groups, let's say, below the federal
13 poverty level or below 138 percent of the federal poverty
14 level, for certain race or ethnicity groups or for children
15 with special health care needs, you get some very small
16 samples. So in some cases we have to combine several years
17 of data even to get those estimates.
18 As a result, there are some estimates that we
19 would very much like to see, but we do not have a
20 sufficient sample, no matter how many years we cross.
21 So I'm going to give you just some teasers of
22 charts and tables that will be in these reports. The

1 reports are very data-heavy. They're basically charts like
2 I'm going to show you, with a little bit of text, but the
3 focus is on getting the numbers out here.
4 So this one, the first chart that we have, table
5 that we have, is just the number of office-based visits,
6 and this is from the MEPS, and it's office-based or clinic
7 visit. So it does not include emergency department visits.
8 And you can see that for all children aged 0 to
9 18, privately insured children, more of them have a visit
10 than Medicaid, and it is significant. The star is it is
11 significantly different.
12 When you look at the red circle, however, if you
13 look at people who are self-identified as Hispanic, that is
14 no longer significant. However, for white non-Hispanic
15 children, the difference is still significant, and
16 similarly, for black non-Hispanic children, the difference
17 goes away. So you do see differences.
18 And similarly, for poverty level, when you look
19 at just children below 138 percent of the federal poverty
20 level, there is no difference in number of visits, but
21 there is for children above 138 percent of poverty. So you
22 do see differences when you stratify by these variables.

1 COMMISSIONER COHEN: Amy, this is probably a
2 really dumb question. This is percent, right? These are-
3 MS. BERNSTEIN: Percent, yes. I'm sorry. I
4 should have put that on. Yes, that is the percent with a
5 visit.
6 Thank you. I'll fix that in the final.
7 So here is -- and I'm very sorry Dr. Cruz isn't
8 here because I thought he would be really interested in
9 this. This is looking at the percent with at least 1
10 dental visit in the last 12 months. Again, this is from
11 the Medical Expenditure Panel Survey.
12 And if you look at children below, children and
13 families below, 138 percent of the federal poverty level,
14 you can see that for Medicaid and for private insurance
15 there is no difference. The same percentage report having
16 a dental visit. Now it's a fairly low percent, but it's
17 the same. When you get above 138 percent, then privately
18 insured children are more likely to have a dental visit
19 than are children with Medicaid.
20 Behavioral health care. Overall, children with
21 Medicaid are more likely to have seen a mental health
22 professional, and to have seen or talked to a doctor about

1 emotional problems. This has two different years. So if
2 you look -- in general, when you look at Medicaid and CHIP
3 for children above 138 percent, children with Medicaid
4 still have more than privately insured children. However,
5 for below 138 percent, that's not the case. So, again, you
6 see some differences.
7 For emergency department visits, you've seen some
8 of these data before. But when you can stratify, you can
9 see that for almost everything, no matter what, Medicaid
10 children below 138 percent or above 138 percent of the
11 federal poverty level have more reported access problems
12 than privately insured children. And you've seen this in
13 other reports that we have done.
14 CHAIR ROWLAND: I think when the problem was too
15 serious for the doctor's office of clinic is a very nice
16 indicator to use.
17 MS. BERNSTEIN: Oh, okay. Well, that one is not
18 different for children below the poverty level. So, I mean
19 -- and this does get you some more granular differences
20 that, you know, may or may not be comparable above and
21 below 138 percent.
22 We also looked at special health care needs, and

1 this is something that you've talked about a lot, which is
2 access to specialty care. And for children with special
3 health care needs, children with Medicaid do report more
4 problems accessing specialty care than privately insured
5 children as do children with no special health care needs.
6 So this is something that may come up in the future.
7 So those are one chart each from some of these
8 reports that we're going to put out, and hopefully, again,
9 you will see them soon.
10 We're also working on a bunch of other things.
11 This is an internal analysis of provider supply.
12 And as you all know, supply of providers is an important
13 determinant of access, and there really is a lack of
14 federal data on who treats Medicaid patients at the federal
15 level. States have some data, but we do not have access to
16 it, and there are few available data sources or studies
17 that really document what's going on with respect to
18 supply.
19 What we're doing in this new analysis is we are
20 basically culling the MSIS data, sort of all of it, and
21 linking provider specialty to the service providers in all
22 of the claims and encounter data, where possible. So this

1 has been a sort of daunting task. When we were talking
2 earlier about data, the National Provider Identifier is not
3 always clearly or well-identified in data that are
4 submitted to CMS.
5 So we have gone through; we have found the fields
6 where these IDs live, which they should be in one field,
7 but they're not always. But we've tracked them down, and
8 we've linked them to provider specialty, which includes
9 physician specialty, whether they're a mid-level
10 professional, whether they're a behavioral health
11 professional.
12 So we will have a state-by-state list of
13 providers who serve Medicaid patients by state. So we can
14 tell you how many, and then we can also tell you how many
15 per population, and then we can also look at who serves
16 them.
17 So that will be, I think, the basis for a lot of
18 additional studies. In addition to this really important
19 baseline data, we'll be able to look at it by specialty,
20 and then we can start looking at, as has been mentioned,
21 enrollees who have specific diagnoses or procedures, and
22 who treats them. So this is the start of, we believe,

1 something really big.

2 And in our first analysis, which we hope to
3 present to you in the winter in one of the next meetings,
4 will be able to look, in addition, at whether these
5 providers by specialty are receive fee-for-service
6 payments, encounter payments, managed care payments, or
7 both. It's not clear that there are not a lot of providers
8 who may be getting both. You know, they could be in
9 different networks and get paid differently. And then the
10 question of incentives for payment come up.

11 Last of all, we have started and are commencing
12 some contracted studies. We have already begun a study of
13 non-emergency medical transportation. As you know, this is
14 a mandatory Medicaid benefit and is considered a barrier
15 for many people. The configurations of non-emergency
16 medical transportation vary considerably, as you know, by
17 geography and need and policy priorities and funding and
18 other things.

19 We have contracted with Burns and Associates.
20 This was started, excuse me, a while ago, and there are two
21 major phases -- a background paper which describes sort of
22 the state of non-emergency transportation, what the models,

1 the broker models, the non-broker models, and also a
2 feasibility analysis of what we can learn from data in
3 different states.
4 So we are -- we have finished the background
5 paper, which we are sort of revising now, and then we're
6 going to start looking at some state data. And we will --
7 we haven't yet quite figured out what the analysis is for
8 the state data, but we will be doing an analysis for the
9 state data on non-emergency transportation.
10 CHAIR ROWLAND: Amy, since one of the things that
11 waived in several of the state waivers is non-emergency
12 transportation, I think it would be very important to know
13 how that benefit works and how it's used but also whether
14 there's any evidence that comes out of the waiver states
15 about what it meant to eliminate non-emergency
16 transportation.
17 MS. BERNSTEIN: Okay. We can certainly do that.
18 The last studies I'm going to talk about are
19 things that we are just starting to think about.
20 We are -- we haven't signed it yet, but we are
21 working with the Urban Institute to see if they will do a
22 contract to examine care for potentially preventable

1 conditions using MSIS data, and this would be probably the
2 3M preventable conditions that have been used in other
3 analyses.
4 And then we are also investigating using these
5 same conditions in an all-payer database to compare whether
6 privately insured patients have different patterns of
7 preventable conditions.
8 CHAIR ROWLAND: For the record, say what the
9 conditions are.
10 MS. BERNSTEIN: Sorry?
11 CHAIR ROWLAND: For the record, say what the
12 conditions are.
13 MS. BERNSTEIN: Oh, we haven't decided what the
14 conditions are yet. I mean, there's a whole series of
15 potentially preventable conditions, and we have not
16 finalized the actual conditions yet.
17 CHAIR ROWLAND: But things like related to
18 diabetic care?
19 MS. BERNSTEIN: Well, the major categories are
20 complications, different kinds of complications, and then
21 also things that could be avoided that you should not have
22 at all, that could be avoided by appropriate care. So the

1 main one is complications, but there's also -- I can't
2 remember what the other list is.
3 EXECUTIVE DIRECTOR SCHWARTZ: Admissions for
4 certain types of conditions, readmissions for other
5 conditions?
6 MS. BERNSTEIN: Yeah, yeah. But we haven't
7 decided what the conditions are. So I can't -- I mean,
8 it's sort of -- and there's hospital-based ones and ones
9 that use all of the data. So there are sort of two sets.
10 So we haven't decided what the hospital ones. So
11 the reason I'm struggling here is I don't know exactly
12 which hospital conditions we'll use and which non-hospital
13 conditions we'll use, but they have been sort of
14 preselected.
15 CHAIR ROWLAND: I wasn't actually asking you
16 which conditions you would actually use. I was just asking
17 you to explain to the group what kinds of conditions.
18 MS. BERNSTEIN: Ah, okay. I'm sorry. These are
19 conditions that should not have occurred, like
20 complications.
21 CHAIR ROWLAND: Or ambulatory-sensitive.
22 MS. BERNSTEIN: Or ambulatory-sensitive

1 conditions or -- I forget what the other term is but things
2 that could have been treated in the community, like
3 community-acquired pneumonia; that should not be the cause
4 for hospital conditions, or gangrene due to diabetes or
5 diabetic retinopathy due to diabetes or things that could
6 have not -- could have been prevented.
7 But, sorry. But we have not yet decided on what
8 they are.
9 And then last of all, I'm just going to put out a
10 plug. We have another special solicitation. We've done
11 two of these so far, and we've gotten some really
12 interesting ideas from our pool of contractors, and we
13 believe that many of them will be related to access. So
14 they will be coming in, in January, and the proposals
15 probably won't come out until the spring. So I just
16 thought I'd tell you about that.
17 And I'd be happy to take any questions.
18 CHAIR ROWLAND: Okay, Sara and Mark, Sheldon.
19 COMMISSIONER ROSENBAUM: This is fabulous.
20 One question. I'm sure I know the answer to it,
21 but I thought I would ask. The ED visit chart among
22 children by age. I assume that one of the possible answers

1 that could be given is not a preference for using emergency
2 departments.
3 And the reason I ask is because one of the things
4 you hear a lot is that there are certain people who prefer
5 to use emergency departments. I actually have never met
6 anybody who prefers to use an emergency department. But,
7 you know, what do I know?
8 But I just wanted to be sure that a question that
9 goes to individual parental behavior in that sense, that
10 sort of an innate preference for, is not something that we
11 can capture in the health interview survey. I assume that,
12 in fact, it would be one of the areas where we find no
13 difference actually between how privately insured people
14 and publically insured people feel about using emergency
15 departments. But it's such a common assertion that I just
16 wondered if there's anything that sheds light on people's
17 preferences.
18 MS. BERNSTEIN: There is no question about
19 preference for using emergency departments.
20 COMMISSIONER ROSENBAUM: And my other question
21 goes, again, sort of going back to the prior discussion.
22 These are great measures, but the place where there has

1 been this huge ferment -- I mean, you know, the disputes
2 that ultimately led to where we finally got to in Armstrong
3 and many of the disputes that go on have to do with access
4 to appropriate care among people who have devastating
5 levels of disability. And we don't really have -- it
6 doesn't look like there's anything that we can capture from
7 these sources that goes to that population, I assume.
8 MS. BERNSTEIN: Unfortunately, the surveys are on
9 the non-institutionalized population.
10 COMMISSIONER ROSENBAUM: Right. So there's no
11 way to get at that, okay.
12 CHAIR ROWLAND: Okay. I have Mark next.
13 COMMISSIONER HOYT: Maybe you know this already,
14 but just to be sure... Mercer -- and I'm sure some other
15 actuarial firms by now do this as well -- for probably 10
16 years or so, has screened data for potentially preventable
17 admissions using the AHRQ criteria. And I don't know if
18 you were trying to think of the abbreviation, LANE, low-
19 acuity, non-emergent conditions, where they would look at
20 care that was provided in a setting, usually the emergency
21 room, where it could have been provided some place else.
22 And they actually comb through the data that's submitted by

1 the plans and discuss it with them and actually reduce the
2 rates, which is a difficult discussion, but to try and
3 force personal plans to manage the care in more appropriate
4 settings.
5 And I think Jim and Chris maybe talked to Mercer
6 actuaries about that before and can provide more specifics.
7 CHAIR ROWLAND: Sheldon.
8 COMMISSIONER RETCHIN: Can you go back to the
9 provider supply analysis that you spoke about, Amy, just to
10 understand where you're going with this?
11 But I was surprised that -- I guess slide 14 may
12 be describing -- I've used the National Provider
13 Identifier, I think, but I'm not sure of the granularity on
14 that.
15 So you were mentioning geographical, the state-
16 by-state, right? So what kind of detail does it get down
17 to in terms of geography? How does that work?
18 MS. BERNSTEIN: Well, we have what the provider
19 ID is on the claim or the administrative data.
20 COMMISSIONER RETCHIN: Okay.
21 MS. BERNSTEIN: So there's a record; there's a
22 provider ID. We link that to their specialty. So you can

1 do anything with it that you can do with regular MSIS data.
2 So we know -- I believe from the taxonomy we know
3 the zip code of the provider, but that's sort of not what
4 we're using to start with. We're just starting with claims
5 submitted by the state. So the state has, you know, three
6 billion records or whatever.
7 COMMISSIONER RETCHIN: Right.
8 MS. BERNSTEIN: We go through, and then these are
9 the providers that are identified from those state data.
10 COMMISSIONER RETCHIN: So I guess where I was
11 going -- I mean, this is seems to be, in my view, a very
12 important analysis in terms of workforce availability.
13 What it probably doesn't get to, that you might
14 be able to impute, is if you go to the last bullet,
15 receiving fee-for-service or managed care payments, since
16 you know the geography of the provider, wouldn't you then
17 be able to look at managed care penetration level? So you
18 would be able to maybe make some assumptions about provider
19 deserts or Medicaid provider deserts?
20 MS. BERNSTEIN: We have not investigated that,
21 sort of what links to what and what you can do at what
22 granular level. We can do the patients by county, in

1 theory, but that's a lot of work, and we sort of aren't
2 there yet. But we can think about it as sort of a future
3 possible thing. We're trying to get through this at the
4 state level first and then we'll move on.
5 COMMISSIONER RILEY: I guess -- this is not my
6 field but it strikes me that, do we really know -- is this
7 data that's -- can you get an attribution? Do you know
8 for, example if so many physicians are owned by hospitals -
9 - a hospital that's in a metropolitan area owns physicians
10 all around a big area. You would only know -- correct? --
11 the provider, the hospital, and not necessarily -- oh, you
12 would know?
13 COMMISSIONER COHEN: It depends, like, what
14 operating license.
15 COMMISSIONER RILEY: Okay. So it's still -- so
16 even if it's a physician-based practice you'd know that
17 they were --
18 MS. BERNSTEIN: It's really complicated. It
19 depends if they have different practices and which one they
20 report.
21 [Simultaneous discussion.]
22 MS. BERNSTEIN: It's -- it -- you know, you sort

1 of have some information on the patient but not
2 necessarily, and you have some information on the provider,
3 and there's organizational providers, where you might not
4 know exactly which provider, you know, rendered the
5 service. It's just really complicated. I can't give you a
6 simple answer but it's not as easy as it might appear.
7 COMMISSIONER RILEY: [Off microphone.]
8 MS. BERNSTEIN: We'll know whether it's from an
9 encounter or a claim, so we'll know -- we won't know
10 necessarily what plan but we'll know -- we'll know if the
11 provider received an encounter record. I mean, if somebody
12 was in managed care and they only billed through
13 encounters, we will know that that provider only had
14 encounters.
15 CHAIR ROWLAND: I have Peter and then I have
16 Andy, Chuck, and Patty.
17 COMMISSIONER SZILAGYI: Yeah, thank you. This is
18 really interesting data. I have a couple of thoughts.
19 From universities, we were never able to -- when we
20 analyzed MEPS we were never able to get to state level or
21 compare fee-for service versus Medicaid managed care. But
22 could MACPAC do that, because would we, at MACPAC, have

1 availability for that public use MEPS?
2 MS. BERNSTEIN: MEPS is just not designed to
3 produce state estimates. They will not produce -- I mean -
4 -
5 COMMISSIONER SZILAGYI: They won't help us do
6 that?
7 MS. BERNSTEIN: They can't. They don't have
8 enough sample to do it. The design of the survey was not
9 designed to there's just not enough people per state to
10 do it. The Health Interview Survey can do it for, I think,
11 34 states, but even the Health Interview Survey can't
12 produce state estimates for all states.
13 COMMISSIONER SZILAGYI: MEPS has expenditures,
14 and so for them to get expenditures they have to figure out
15 what the expenditures actually were. That's where --
16 that's what is good about MEPS. So I would think that they
17 would be able to figure out whether that was managed care
18 versus fee-for-service, for them to get the exactly dollar
19 value of the expenditures. Expenditures doesn't come from
20 patients' MEPS.
21 I would just -- I would just try to pursue it, to
22 see whether it's possible, because this question about is

1 this managed care or fee-for-service is sort of a really
2 fundamental question.
3 MS. BERNSTEIN: They just go to the provider, but
4 I'm pretty sure that they don't record, sort of, what the
5 characteristics of the provider are. The person writes
6 down what they spend. Then they do a follow-back to the
7 provider, and they say, "How much was paid by the patient
8 and how much did this cost?"
9 COMMISSIONER SZILAGYI: We were never able to get
10 it, but I was just wondering whether --
11 MS. BERNSTEIN: Yeah, but --
12 COMMISSIONER SZILAGYI: The other point I was
13 going to make is that one of the rich sets of questions in
14 MEPS is unmet needs, a whole set of questions about unmet
15 needs, and that would be a really good comparison between
16 Medicaid and the private world, within the MEPS analysis.
17 CHAIR ROWLAND: Andy.
18 COMMISSIONER COHEN: First I just want to say
19 this is great stuff that we're getting into. I think it's
20 really wonderful and will really make our, you know, some
21 areas of work much richer, so congratulations to you, and
22 to us. I think it's really great that we have this.

1 I did have a question, maybe a comment or a
2 question, about the, sort of looking at utilization,
3 comparing utilization across kids with, or people with
4 Medicaid, starting with kids with Medicaid at different
5 poverty levels and those with private. I assume, at some
6 point, this will have to be sort of matched up in some way
7 to disease prevalence or condition prevalence or other
8 things, because, you know, of course utilization doesn't
9 tell us everything we need to know about access, and we
10 also know that kids at different levels of poverty may have
11 different disease or condition patterns.
12 So, you know, it jumped out at me in a couple of
13 spots, but, you know, just in terms of thinking about
14 behavioral health visits, for example -- first of all,
15 they're actually very -- you know, there are many --
16 there's severe utilization of behavioral health services in
17 Medicaid, for lots of reasons, including it covers a lot
18 more than most private insurance, including that there may
19 be more conditions because of the conditions of poverty and
20 other things.
21 But anyway, I just want to make sure that that
22 kind of analysis is, at least, you know, to the extent it

1 can be sort of factored in, mentioned as a caveat,
2 something like that, that would seem extremely important.
3 Both otherwise, great. Great stuff.
4 CHAIR ROWLAND: Okay. Chuck.
5 COMMISSIONER MILLIGAN: Just actually two
6 comments. The first is Slide 10, which was the ED slide.
7 I just -- Amy, you made the comment that there's evidence
8 of an access problem because of the data, comparing
9 Medicaid and private. I would just be cautious about
10 drawing conclusions from the data like that. When you look
11 at the data on the use of the ED by the uninsured, it's
12 often below Medicaid, and they have even less access.
13 There is a school of thought that Medicaid access
14 is higher partly because there's a lot of first-dollar
15 coverage in most states and with private insurance, and the
16 uninsured there's a lot more out-of-pocket sort of self-
17 censorship or self-editing because of financial risk.
18 And so I just would be cautious about drawing
19 conclusions. I think the data is very helpful, but I don't
20 know that it tells us definitively why.
21 The second comment I would make is actually going
22 back to the first part of the session with Anna, and just

1 for my fellow commissioners, I think part of the reason
2 that CMS might not have gone as far with the access rule as
3 others would like is the litigation that started this rule
4 back 4 years ago was coming, typically because the Ninth
5 Circuit Court of Appeals on the West Coast was enjoining
6 states from cutting Medicaid rates, when states had budget
7 problems and providers said it's going to hurt access. And
8 the Ninth Circuit -- you could have a whole sort of
9 conversation about this, but it basically said if CMS has
10 vacated the playing field, we have to weigh in, because
11 there's no measure here.

12 And so I think, ultimately, the access rule came
13 out defensively from CMS, saying "we want to control the
14 oversight. We don't want the courts controlling oversight
15 of Medicaid rate-setting. We'll do that." But I think,
16 ultimately, they didn't go very far because it's a very
17 third-rail issue for CMS to start getting into the business
18 of dictating what states should pay. And so I think that
19 we have to kind of go into this rule knowing that it's
20 really first-level, first-blush effort in this area for
21 CMS, and to help with MACPAC over time refine the access
22 measurement to help CMS evaluate those access plans, and I

1 think, Amy, this research that you've shown us in the
2 second half will help inform that debate. But I do think
3 that underneath all of this is rates, and whether and to
4 what extent the federal government gets in the business of
5 dictating rates, or barring states from changing rates, and
6 that's a tough issue in both directions.
7 So thank you.
8 CHAIR ROWLAND: Amy, can I ask you a question? I
9 know you just were showing us one table from each of these
10 briefs. Did you run this same table to look at what the
11 distribution of these visits were by these indicators, you
12 know, how many -- you know, are Medicaid patients more
13 likely to have as their primary reason for going to the ER
14 that their doctor's office was not open? You've run the
15 rows and I'm asking if you --
16 MS. BERNSTEIN: Oh yeah, sure. No, absolutely.
17 Well --
18 CHAIR ROWLAND: Because I think that's also
19 instructive too, to just look at the distribution of ED
20 visits by these outcomes.
21 MS. BERNSTEIN: Well, one of the challenges of
22 these reports is we ran everything by everything, and

1 putting it into an eight-page paper, it's sort of figuring
2 out what the most important points are. So sometimes it's
3 the row percents, and sometimes it's the column percents,
4 and sometimes it's the trends, so it's hard to just give
5 you a taste of the 9,000 pages of output.
6 COMMISSIONER MILLIGAN: But part of -- what the
7 states that have done the Medicaid expansion have seen is
8 that ED visits go up when people are leaving an uninsured
9 status, where you have to worry about financial assistance
10 policies and bill collectors for Medicaid. So I just want
11 to be careful about drawing too many conclusions about
12 utilization as an indicator of access versus utilization as
13 an indicator of coverage.
14 VICE CHAIR GOLD: Sort of just picking up that
15 point quickly, I think, looking at some of those reasons
16 and looking at the ones that are more or less sensitive to
17 an access problem, helps you. You also could look at
18 people who are a payer for health, if that's a good enough
19 number that you can look at, and sort of being sensitive to
20 how do we interpret this, that when you're deciding which
21 of those multiple different direction things you look at --
22 I can't remember who made the point, but I think the

1 ability to relate it back to access, to the extent you can
2 with what you're dealing with, is important. So being able
3 to sort of look at things that seem more access-related, or
4 people who seem more alike in their health care needs is
5 important.

6 MS. BERNSTEIN: I just want to point out that on
7 this particular slide -- maybe it's not labeled as well as
8 it could be -- but these questions here, they're not really
9 reasons. If they said "For your most recent visit do any
10 of these things apply?" All right. So it's not why did
11 you go. It's you had a visit and did it result in a
12 hospital admission? Did you child's health provider advise
13 you to go. It wasn't a choice issue. It was just these
14 are things that were asked. So we're kind of limited to
15 what the questions are on the surveys, but we can certainly
16 choose the ones that we believe are more access-related, to
17 your point.

18 CHAIR ROWLAND: I have Patty, Steve, Donna.

19 COMMISSIONER GABOW: On the ED thing, I think
20 there's another growing, confounding variable here, and
21 that is urgent care centers. In the private sector there's
22 a strong move to take people who could go to an ED and sort

1 of, both the patient prefers the urgent care facility in
2 their mall compared to a hospital ED. But as far as I am
3 aware -- but someone should verify this -- those urgent
4 care facilities do not take Medicaid, and they certainly
5 don't take the uninsured unless they're paying cash. So I
6 think that's going to make this even more difficult to
7 interpret, and you're going to see the gap widen.
8 If you have no option for the lower level of
9 care, then you will use the higher level of care. These
10 urgent care facilities are springing up like rabbits
11 proliferating and everybody is going to be -- I think
12 there's going to be much more use. But if they're not
13 accepting Medicaid, that's going to be -- make this
14 difference. It's just worth verifying, but I'm pretty sure
15 that's the case.
16 CHAIR ROWLAND: Steve.
17 COMMISSIONER WALDREN: So on the NPI, you can use
18 the national plan and provider enumeration system to get
19 them to actually house level for the practice. The
20 problems are is that that's manually entered data by the
21 provider. It's not super reliable. And then you also have
22 some providers who are in multiple locations, so you don't

1 know if that's their location, one of their locations, or
2 the location of their parent organization. You don't have
3 that parent linkage.
4 So what I've done is done some analysis that you
5 can actually look at city, state, and ZIP, and then you can
6 use the U.S. Postal Service codes to figure out, are those
7 cities and states actually in that ZIP code and get some
8 validity checks. I think you can do ZIP code level pretty
9 decently with that data. The other thing you can do is you
10 can map that to the AMA master file, looking at specialty
11 codes, because we've found that those are not all that
12 accurate, that allow you to put multiple ones in the MPES.
13 And finally, you can also link that to the SK&A,
14 which is a vendor that has this type of data to validate
15 against those two other data sources, plus you have the
16 ability to look at ownership. So they actually have, are
17 they linked to a hospital? Do they participate in a
18 hospital distribution, so do they actually admit patients
19 to particular hospitals who are part of an ACO?
20 So I think with all three of those we have that
21 NPI. You can get it and get it reliably. There's a lot of
22 great things that you can do about that. So I think that's

1 wonderful and we should continue to push forward on that.
2 The challenge for me on the access, though, is
3 that we can't measure need very well, and that's really, I
4 think, the problem, because think about three cohorts of
5 Medicare patients with diabetes. The first cohort gets
6 seen every 6 months. The second cohort gets seen every 3
7 months. The third cohort gets seen every month. Which
8 cohort is having an access issue, or multiple ones, or
9 which ones are over-utilized?
10 So what if, in the first one that's seen every 6
11 months, what if you're stable, doing really well, and you
12 have a monthly call with the nurse in the practice. Well,
13 you really don't have an access issue. Actually, you don't
14 even have an overutilization issue. But then maybe those
15 in the 3 months, okay, they're having to kind of be seen
16 every time, and then you have people that are really
17 brittle, that are really out of control. So now do you
18 look at the hemoglobin A1C and see what the control is?
19 So I like these types of measures because they
20 are the closest to be able to say, "Does the patient feel
21 like they can get access?" I would add to this asking the
22 primary care docs, do they have access issues getting their

1 patients that they see, to see specialists or be admitted
2 to a hospital? And again, you have survey data that's
3 limited, but I think that's going to be the closest we're
4 going to be able to get without spending, you know,
5 millions of dollars to try to figure out, is there a
6 particular access issue in a particular place.
7 COMMISSIONER CHECKETT: So just an observation,
8 and I think it is not something that we can ever or --
9 easily or maybe even ever really get at with data, but as
10 Sara said, I think, as we opened the discussion, particular
11 on ER -- and I'm fascinated by the fact that we spent so
12 much time talking about ER, and in my 25-plus years of
13 working in Medicaid, you always talk about overuse of ER,
14 perceived overuse of ER by Medicaid beneficiaries. And I
15 think it's an issue. I'm increasingly aware that for some
16 subsets of the Medicaid population, we make assumptions
17 about ER use that I think does not acknowledge the fact
18 that for some families that is simply where they go, that
19 is simply where they get care, and that is not so much
20 perhaps cultural but certainly a function of where they've
21 lived. And so when you start questioning about like, "Why
22 did you go to the ER?" at some levels it's questioning

1 almost like, "Why did I take my child to get medical care?"
2 And so I think as hopefully there's better
3 access, and especially in urban areas where I think this is
4 really a tradition, at some point that might start to be
5 mitigated. But I think as we try to be both culturally
6 sensitive and respectful of that, that's something not to
7 lose sight of. So just a comment.
8 CHAIR ROWLAND: You know, I also think we should
9 follow up on Patti's comment about the alternatives to the
10 ER that are cropping up, and urgent care centers, where
11 they're located and whether they take Medicaid or not, is
12 one issue to look at. But there's all these Minute Clinics
13 that are in the CVSes and whatever, which we know are in
14 many low-income neighborhoods. And so I think the more we
15 can look at kind of how access patterns are also changing
16 would be very helpful.
17 COMMISSIONER ROSENBAUM: I also think another
18 confusion point, there's sort of nothing we can do about
19 it, at least not that I'm aware of -- and I'm just
20 wondering if anybody has any ideas -- is that if you asked
21 people 15 years in Washington, "Where did you get your
22 care?" they'd say, "D.C. General," if they lived east of

1 the river, particularly. And D.C. General had both
2 outpatient clinics, it had an emergency department -- I
3 mean, this was a hospital, so there were a lot of different
4 things. And I'm not sure that people who are accustomed to
5 getting health care through an institutional provider -- so
6 they don't go to a suburban doctor in the doctor's office -
7 - would necessarily know if what they're going to is an ER,
8 an outpatient clinic, whatever. What they know is they go
9 to D.C. General.
10 And so I think this whole issue of -- which is
11 just always, I assume, a limitation in all of these
12 studies, a terminology issue. You know, when you ask
13 someone, "Do you go to the ER?" whether the questioner and
14 the questionee are on the same wavelength is an issue.
15 And so I think that while we can probe -- and
16 this is a wonderful contribution, especially since it will
17 come out in bursts and come out frequently, which I think
18 is the way to do it, as opposed to, you know, one large
19 compendium that gets forgotten, sort of a constant way of
20 doing this.
21 But I think we have to be very clear with people
22 or with readers and users of the data, all the things we

1 don't know at the same time we're making charts about the
2 things we can tell you, because I think there's a very fast
3 rush to judgment always, especially when you can't read
4 charts easily, "Well, look at this, Medicaid beneficiaries
5 use the emergency department a lot more." You know, that
6 if you really want to sum up the emergency department
7 slide, that's what it says. Now, we all know that there's
8 so much going on in this slide, so I think limits on what
9 we say, and while I certainly appreciate the need to focus
10 on the slide, I think we have to have some text surrounding
11 the slides, because they're just -- they're hard to sort of
12 have sink into your head if you don't look at these data
13 all the time.

14 DR. BERNSTEIN: And that's why we're doing these
15 little briefs as reports, not just as table shells.

16 VICE CHAIR GOLD: What I was going to talk about
17 before -- and I think it does make more sense after
18 listening to the good work that people are doing here -- is
19 a sense I had listening around the table as to how we see
20 these issues, which we either can decide to forward on to
21 CMS as feedback on the final rules or just keep in mind
22 here, is it seemed like I was hearing people say that

1 ultimately we want to be able to look across a whole
2 program, people may be getting care in a managed care
3 sector or fee-for-service sector, but we want basically the
4 accountability rule for the beneficiary, so we want to look
5 across those sectors and realize how much different it is
6 that -- you know, which parts are served by what, but have
7 some uniformity.
8 Two, we want to ultimately get to the point where
9 at least to the extent feasible there are some targets or
10 some standards of looking at it.
11 And, third -- and this is sort of more my
12 adaptation to what someone said -- is we want to sort of
13 have realistic estimates for what it costs to develop
14 these. But I think when we do that, we have to recognize
15 that some of this is basic information that supports a lot
16 of uses, and it may not be new money. Like there's a lot
17 of reasons to do surveys in Medicaid, to have some basic
18 data done, and those aren't necessarily new costs just to
19 have an access plan. And there may be lots of other uses
20 for those data. So while we want to be realistic with what
21 it takes, we also want to recognize there's some
22 fundamental infrastructure you need to run a program that

1 has lots of different applications, and this may not all be
2 new money, and it may be serving a lot of other purposes.
3 CHAIR ROWLAND: Just to wrap this session up, I
4 think given that access is in our name, it's great that we
5 are really plunging ahead on trying to look at all the
6 various dimensions of the access issue. I think this is a
7 great start, and I'm glad you're going to be putting out
8 these issue briefs.
9 I concur with the comment that, you know, putting
10 them in context so that we can also help set up what the
11 next set of our research agenda is would be very helpful.
12 And since we like commenting on reports, the
13 Secretary's report on 115 waiver transparency is the next
14 issue on our agenda.
15 For this report, it's the requirement that on
16 secretarial reports to the Congress within six months of
17 the issuance of such reports, we will provide comment. So
18 that is one of our statutory obligations, and Rob is
19 getting a little water to help him get through his
20 presentation.
21 **### Review of Secretary's Report on Section 1115**
22 **Waiver Transparency Requirements**

1 * MR. NELB: Thanks, Diane. This morning I'll be
2 briefly reviewing HHS' recent report to Congress on Section
3 1115 demonstration transparency, which was released in
4 October of this year.
5 I'll begin by just providing some background on
6 Section 1115 demonstrations and particularly on some of the
7 new demonstration transparency requirements that were added
8 by the Affordable Care Act. And then I'll summarize HHS'
9 recent report, which mainly focuses on its implementation
10 of these ACA requirements.
11 Finally, to facilitate your discussion, I'll
12 highlight three potential areas for Commission comments:
13 strengthening and monitoring the evaluation reports for
14 demonstrations, opportunities to improve the transparency
15 of budget neutrality and other HHS approval criteria, and,
16 finally, opportunities to reduce administrative barriers
17 for states.
18 So to begin, a refresher on some background. As
19 you know, Section 1115 demonstration authority is one of
20 the broadest demonstration waiver authorities available in
21 the Medicaid program, and under Section 1115 the Secretary
22 has very broad authority to approve pretty much any

1 demonstration that promotes Medicaid objectives.

2 As of September 2015, a total of 55

3 demonstrations were operating in 38 states. Some states

4 used Section 1115 authority to operate most of their

5 Medicaid program while others used these demonstrations for

6 more modest changes, such as adding particular benefits.

7 And because of the broad authority of Section

8 1115, there's really a wide range of different types of

9 demonstrations that have been approved. Some current types

10 include premium assistance demonstrations and other state-

11 specific approaches to the Medicaid expansion; delivery

12 system reform incentive payments, or DSRIP, which we've

13 talked about; managed long-term services and supports; and

14 family planning benefits.

15 Now, it's important to note that Section 1115 is

16 not the only authority that states can use to make some of

17 these changes to their Medicaid programs. There's other

18 authorities that also provide, for example, managed care

19 authority. But Section 1115 is unique in the breadth of

20 flexibility that it provides.

21 So really the use of 1115 authority in Medicaid

22 grew in the 1990s and early 2000s, and as that grew, the

1 Government Accountability Office has been taking a closer
2 look at HHS' review and approval process. And since 2002,
3 GAO issued a number of reports recommending some improved
4 transparency to the demonstration approval process.
5 In response to some of these concerns from GAO
6 and others, the Affordable Care Act added several new
7 transparency requirements for demonstrations. The full
8 text of the relevant statute is in your materials in
9 Appendix A. I just want to highlight three areas in
10 particular.
11 So, first, the ACA included requirements for
12 state and federal public notice on pending demonstration
13 applications so that stakeholders have an opportunity to
14 comment before the demonstrations are approved.
15 Second, the ACA added some requirements about the
16 monitoring and evaluation of demonstrations, including
17 requirements for HHS to periodically conduct federal
18 evaluations of demonstrations.
19 And, third, the ACA added some new requirements
20 for HHS to provide some more clarity about the goals and
21 expected costs of demonstrations.
22 The report we're reviewing today was also

1 required by the ACA, and it will be an annual requirement
2 for HHS. In this first report, HHS primarily focuses on
3 its implementation of the first requirement, the public
4 notice requirements of the ACA, but I wanted to point out
5 some of these other areas of the transparency requirements
6 as well in case you want to comment on them.

7 So turning to the report itself, as I mentioned,
8 it primarily focuses on describing HHS' implementation of
9 public notice requirements through new regulations that it
10 issued in 2012. These regulations added several new public
11 notice requirements, including requiring states to hold at
12 least two public hearings before submitting demonstration
13 application requests, establishing a minimum public comment
14 period for federal review, and requiring many demonstration
15 application documents to be posted online.

16 In HHS' report, they note that most states have
17 been compliant with the new rules, and since April 2012,
18 HHS has received more than 1,500 public comments on
19 demonstrations, some of which have prompted additional
20 follow-up with stakeholders.

21 The report also briefly mentions some additional
22 approval criteria for demonstrations that HHS has developed

1 for its review of Section 1115 demonstrations. These
2 criteria weren't part of the 2012 regulations, but they
3 were added to CMS' website earlier this year in response to
4 some GAO concerns about whether some spending authorized
5 under demonstrations furthered Medicaid objectives.
6 HHS partially concurred with GAO's recommendation
7 to clarify its approval criteria and developed the four
8 principles here to evaluate whether these demonstrations
9 are likely to promote Medicaid objectives.
10 In general, the demonstration request must meet
11 at least one of these four criteria, and in all cases they
12 should be focused on low-income populations, that is,
13 Medicaid or low-income uninsured.
14 Now, in addition to meeting requirements for
15 furthering Medicaid objectives, HHS also requires
16 demonstrations to be budget neutral, which means that the
17 projected costs under the demonstration are less than
18 projected costs in absence of the demonstration. However,
19 HHS doesn't provide similar guidance on sort of the
20 principles behind its budget neutrality calculations.
21 Finally, the report also just mentions some
22 recent improvements to HHS' review process for

1 demonstrations that I wanted to highlight. In July of this
2 year, HHS provided a new fast-track review process for
3 certain demonstration requests, and by using a standardized
4 template, HHS intends to shorten its review timeline for
5 these requests to about 90 days, which is about the same
6 time as a state plan amendment. However, only a few states
7 are eligible to participate. They're only eligible if
8 they're not proposing major policy changes or if their
9 demonstrations don't involve complex policy areas, such as
10 DSRIP or the Medicaid expansion.
11 All right. So that's a high-level summary of the
12 report. Now, to turn to your discussion. As Diane
13 mentioned, because this is a report to Congress, MACPAC has
14 the opportunity to comment through a formal written
15 response letter. And I want to point out that, in addition
16 to commenting on the specific changes described in the
17 report, such as HHS' improvements for public notice, the
18 Commission could also use this opportunity to comment on
19 broader demonstration transparency issues, such as some of
20 those ACA requirements that weren't fully addressed in the
21 report.
22 For example, as I mentioned, the ACA includes

1 requirements related to the monitoring and evaluation of
2 demonstrations, including requirements for federal
3 evaluations, which is a topic that the Commission
4 previously discussed in its work on DSRIP waivers.
5
6 Though not mentioned in this report, HHS has
7 actually begun some federal evaluation of some
8 demonstrations which might be worth noting in the
9 Commission's comments.
10 In addition, as I mentioned, the ACA also
11 includes some requirements related to transparency about
12 the state and federal cost of demonstrations. It's not
13 particularly highlighted in this report, but transparency
14 of budget neutrality has been a longstanding area of
15 concern for GAO and other stakeholders.
16 So, again, to facilitate discussion, I've
17 highlighted the following three potential areas for
18 comments. More information about each of these is in your
19 materials.
20 And I'm happy to answer any questions, but mostly
21 I'll be a good listener to make sure your feedback is
22 incorporated into any response and into our ongoing work on

1 waivers. Thanks.

2 CHAIR ROWLAND: And our comments on this report
3 from the Secretary to the Congress would go to the
4 congressional authorizing committees as well as to the
5 Secretary. So this is not a letter to HHS. It's actually
6 a letter to the Congress, commenting on the HHS report, but
7 it can also give some additional guidance to HHS about what
8 we would like to see.

9 No comments to make? Donna.

10 COMMISSIONER CHECKETT: Well, thank you. I think
11 it's, you know, been some great work the Commission has
12 done so far in just helping all of us better understand
13 waivers and particularly the fascinating and flexible 1115
14 waiver. "Nimble" sometimes comes to mind, which is rarely
15 a word one associates with Medicaid.

16 But I do have a question, and I don't know so
17 much kind of process-wise where it would fit, Diane, but I
18 do really think that it is important to have more
19 transparency around the processes and the decision-making
20 because some things that are done through 1115 waivers are
21 sometimes a little bit surprising.

22 I wonder if -- is there anything that shows like

1 how HHS has responded or incorporated stakeholder feedback
2 so that you're not just having a process where it's
3 transparent; you're having a process, but their mind's
4 already made up? So I'm curious if you can respond.
5 And I don't know, Diane, if that fits into this,
6 but it is, to me, kind of the next logical step.
7 MR. NELB: Yeah. I mean, they don't give
8 specifics in this report, but there have been particular
9 ones I've been aware of, for example, tribal concerns, you
10 know, incorporated into waivers, about whether to include
11 Native Americans in managed care in some states, other
12 examples with some of the new adult group expansions.
13 They talk about the comments prompting sort of
14 follow-up. In addition to receiving the comments, also
15 meeting with some of the stakeholders who raised the
16 concerns. So -- but no specific examples highlighted.
17 COMMISSIONER MILLIGAN: I guess a couple of
18 things I want to raise. One is a gap that seems to exist
19 for me is replication in one state of something that's been
20 proven to be successful in another state, and whether and
21 to what extent that is done, or fast-tracked, how much of
22 an evidence base you need to be able to replicate.

1 But I think one of the issues with 1115s all
2 along has been even if something has been proven in one
3 place, if a new state submits a similar 1115, it's
4 evaluated from scratch. And maybe that's the way it needs
5 to be, but I think that it doesn't create a pathway from
6 something being a demo, where there's research and evidence
7 that it works or doesn't work, and implications outside of
8 that particular state. This has been an issue that's come
9 up in a lot of other contexts, but I think it's something
10 worth keeping on our radar.
11 The second comment -- and I really -- I think I
12 mainly want to open this up to other commissioners because
13 I think -- I read the GAO report maybe September of 2014,
14 as I recall, related to the Arkansas private option, and
15 I'm going to probably get a couple of the facts wrong here,
16 but here's the underlying concern that GAO had and concern
17 with CMS approving that waiver -- was:
18 Arkansas said, if we did the Medicaid expansion
19 under the ACA, we would have to pay providers a 50 percent
20 premium to take on more Medicaid people at a low Medicaid
21 pay scale. So we're going to have to raise our rates a
22 bunch if we're adding a bunch more people to Medicaid. And

1 therefore, if the office visit is going to cost $60 instead
2 of $40, for budget neutrality, that's what we would spend
3 to do a Medicaid expansion, and therefore, let's do the
4 private option because we won't spend more than this
5 hypothetical amount that we've never, in fact, actually
6 spent.
7 And so GAO thought that that was a little cute.
8 And so I think that one of the areas for 1115s
9 and budget neutrality going forward is to what extent is
10 the underlying premise based on actual evidence versus
11 based on a hypothetical because that was a very significant
12 thorn in the side for GAO about the Arkansas private
13 option.
14 CHAIR ROWLAND: To go with your points, Chuck, I
15 do think that one of the things that we really want to
16 emphasize is the need for access to the evaluation and
17 plan, and to the evaluation reports, because if there's any
18 ability to repeat these demos you really want to know were
19 they evaluating the right things and then what was the
20 nature of the evaluation. So I think that is something we
21 could stress.
22 And then the budget neutrality issue, I think, is

1 also one that it's always been a black box and it's always
2 had a lot of hypotheticals in it. And it's still not a
3 statutory requirement so that, you know, what we could
4 perhaps be asking is for better guidance from OMB about
5 what they're going -- what goes into a budget neutrality
6 calculation.
7 I have Sara next, and then I have Andy.
8 COMMISSIONER ROSENBAUM: One area. I have the
9 same thought about the problem with evaluations, not only
10 learning about them but even finding them. I mean, you
11 can't, you really can't, even find the evaluation work at
12 the web sites. It's just very hard.
13 COMMISSIONER GOLD: It's not just --
14 COMMISSIONER ROSENBAUM: Right.
15 COMMISSIONER GOLD: It's not just the state
16 evaluations you mean but any independent evaluations that
17 CMS funds.
18 COMMISSIONER ROSENBAUM: Absolutely.
19 COMMISSIONER GOLD: And I think we want to refer
20 to both.
21 COMMISSIONER ROSENBAUM: Right, right.
22 CHAIR ROWLAND: I do recall that around the dual

1 demonstrations we asked to see the evaluation plan that the
2 federal government was paying for, and it was not
3 available.
4 COMMISSIONER GOLD: Yeah.
5 COMMISSIONER ROSENBAUM: So the thing I want to
6 also pick up on is the following: So when the Secretary
7 grants or exercises her 1115 authority, she's basically
8 writing a rule, and that, of course, is the meaning of the
9 amendments, the ACA amendments on notice and public
10 comment.
11 The interesting thing is that the most important
12 part of the Administrative Procedure Act is really not even
13 so much the opportunity to talk, but it, of course, is the
14 opportunity to talk meaningfully, meaning that the agency
15 has an obligation to tell you in the preamble to a final
16 action, final agency action, what it's doing in response to
17 the comments it's received.
18 Now the interesting thing is that, of course, the
19 1115 amendments are not amendments to the Administrative
20 Procedure Act; they're amendments to 1115. But it is --
21 the statute says you're supposed to be able to -- the
22 process is supposed to ensure a meaningful level of input.

1 From my -- from where I sit, since this amendment
2 has the effect of aligning the 1115 process with the normal
3 process for administrative process, I would like to see us
4 comment that one of the things that ought to accompany the
5 awarding of a demonstration or the extension of a
6 demonstration or the modification of a demonstration is an
7 explanation of the comments that were received and what
8 actions may have been taken in response to those comments
9 because I think what Congress is really getting at in the
10 1115 amendment was the notion that there should be
11 meaningful public participation. And I think the fact that
12 you can write comments is not really meaningful. I think
13 it becomes meaningful when you see what the agency has
14 done.
15 I would assume -- I don't know the -- I mean,
16 I've not studied this issue, so I don't know. When states
17 pursue 1115 applications, in some states I would guess that
18 it is also treated as an administrative action and that the
19 state, of course, now under federal law, has to have, you
20 know, a public comment period. But there may be states
21 where, under state law, the state has to have public -- not
22 only have a public comment period but respond to public

1 comments received.

2 And so I think that in order to make things

3 meaningful this would be a welcome addition.

4 COMMISSIONER COHEN: Just to continue on that

5 theme, I think an area that -- if we have the maybe

6 empirical basis to do so, an area that we might want to

7 comment is my sense is that, pardon me, there are

8 tremendous interpretive issues with respect to what is a

9 waiver or document that has to be made available under ACA

10 or the 2012 requirement.

11 And in my own experience, you know, what we have

12 seen sometimes is that states will submit kind of a concept

13 paper to CMS and say, this is our waiver request, and then

14 there are months or years of in-depth back and forth that

15 is not transparent, and then something final emerges. And

16 sometimes there are interim things in between that are also

17 pretty high level and conceptual.

18 So it is -- that, I think, is not really

19 consistent with the spirit of transparency although it may

20 meet the letter of the law. And I also recognize that it's

21 very hard to negotiate details in a political environment

22 completely in public. So, I mean, we all understand

1 the tensions here, but I will say it does -- it might be
2 interesting to just sort of take a little look at sort of
3 like what is sort of considered a formal, you know,
4 communication or submission or proposal to CMS and what's
5 put online sort of compared to what comes out, and whether
6 or not there is real transparency in that negotiation
7 process along the way. You know, detail of what's
8 submitted compared to detail of what comes out, I would bet
9 if you counted pages it would be like, you know, a thousand
10 times the number of pages submitted as the number of pages
11 that come out.
12 CHAIR ROWLAND: It's kind of when does the formal
13 waiver process begin, that it has transparency, as opposed
14 to the informal negotiations.
15 COMMISSIONER COHEN: Exactly.
16 CHAIR ROWLAND: And I think it's important to
17 recognize that sometimes by the time it's the formal one
18 it's all done.
19 COMMISSIONER ROSENBAUM: So it goes to meaningful
20 comment.
21 CHAIR ROWLAND: Right. Mark.
22 COMMISSIONER HOYT: Behind the budget neutrality

1 sort of telling that, I think something Chuck was saying,
2 having done a few cost and caseload estimates in my day, it
3 would be nice if they would disclose the trend assumptions
4 that were approved. Behind both caseload and growth, maybe
5 there was some kind of programmatic change, improving
6 access, changing eligibility itself, by eligibility
7 category. All those should be on like one page somewhere
8 that would make an actuary really happy.
9 And our experience, of course, was there was
10 tremendous variability from one state to the next in the
11 different trend assumptions that were approved, but that
12 would be something that would be interesting to me -- you
13 know, the basic components of that budget and how it was
14 built.
15 CHAIR ROWLAND: It also seems to me that the
16 budget neutrality argument and the documentation of what
17 they expect to achieve is what you want to evaluate, to see
18 how close were they when they started, to say they were
19 going to cover this many people at this cost, and trend it
20 out. So I would emphasize that that point ought to clearly
21 be part of any evaluation planning.
22 COMMISSIONER HOYT: And maybe one last comment

1 tied to that. Let me just come at the tail end of a
2 waiver. Maybe it ties into the evaluation comments.
3 Whenever a state exceeded their cap -- you know,
4 they projected a budget, and then they didn't make it. You
5 know, they overran -- that would be good to know.
6 CHAIR ROWLAND: Don't they usually have a five-
7 year rolling period to -- they don't have to hold to it
8 every year? They can ramp up and down?
9 COMMISSIONER HOYT: They're not always the same,
10 are they? I've heard of some five-year budgets.
11 CHAIR ROWLAND: It depends on the --
12 COMMISSIONER HOYT: On others, it could be a per-
13 capita. Depends on how they filed it, right?
14 CHAIR ROWLAND: Yeah. Any other suggestions for
15 putting together our comments?
16 So I think since we will not meet again before
17 these will be submitted you should provide a draft.
18 And then maybe, Anne, you can circulate the draft
19 to the Commission members to just be sure that you've
20 managed to hit all the points we wanted hit in exactly the
21 way we wanted them stated.
22 UNIDENTIFIED SPEAKER: Verbatim.

1 CHAIR ROWLAND: Verbatim.

2 Okay. With that, thank you, Rob.

3 I'm going to ask if there are any public comments
4 that individuals want to deliver prior to our breaking for
5 our lunch break.

6 Okay.

7 ### Public Comment

8 * MR. HALL: Hi. I'm Bob Hall with the American
9 Academy of Pediatrics, and first, the academy would love to
10 acknowledge the good work that you're doing on the access
11 question and the frustration that it appears you're feeling
12 with these sorts of questions. We've wrestled with this
13 for a very long time, and I think we've come to the
14 recognition that there are actually some relatively simple
15 and easy ways to look at this, at least in the context of
16 pediatric care provided to children in Medicaid. Use
17 Medicare. That's a very simple way to look at these
18 services. We know what those CPT codes are paid at in the
19 fee-for-service context. It shouldn't take too much to go
20 back and find those things.

21 And, in addition, we would advocate for 2014 to
22 be the year that is used at the lookback. We know what

1 those rates were in that year, too. Especially in the E&M
2 code context, this should be simple. So if you're looking
3 for a safe harbor, at least for kids, and at least for
4 pediatric care and, in particular, primary care, we would
5 absolutely urge you to provide Medicare as a possible safe
6 harbor, at least for comparison. That doesn't require that
7 states pay those rates, but it does, I think, follow the
8 philosophy of the regulation, which is transparency. We
9 need to know what these look like in comparison to other
10 services that folks in the United States are receiving.
11 The other thing that we would urge to be included
12 is immunization administration. Kids get a lot of shots.
13 This is a really important, critical framework for public
14 health. Kids get a lot of shots because they work really
15 well and they're really cheap. But it's a large burden on
16 pediatric practices to provide these sorts of services in
17 terms of holding the immunizations, the risk that they
18 take, et cetera. So the immunization administration
19 component would actually be very helpful to, I think, give
20 a picture of what is happening at the practice level and
21 making sure that kids are going to be able to get in there
22 and get what they need.

1 Finally, we're going to be advocating for a
2 federal ombudsman or call center to be created. We think
3 it's important not only to have these services be reviewed
4 at the state level; the state is going to be setting those
5 rates. We're not really certain it makes much sense for
6 them to then receive the complaints about those rates.
7 Generally, that doesn't really seem to be as effective
8 perhaps as what CMS might do. But certainly the academy
9 would really appreciate you all taking a closer look at
10 this and definitely appreciates the work that you're
11 already doing.
12 Additionally, thank you so much for MACStats.
13 It's a really great product and resource, and it's really
14 great to take a look at those sorts of resources, exactly
15 what MACPAC was supposed to do, which is create good data
16 that we can all make better policy on.
17 So thank you very much.
18 CHAIR ROWLAND: Thank you.
19 MS. ALKER: Hi. I'm Joan Alker from Georgetown
20 University, and I couldn't resist popping up to discuss
21 Section 1115 waiver transparency because I think about that
22 a lot, and not a lot of people do. So a lot of great

1 comments, and just a few things to flag, and I'm happy to
2 talk more off-line.
3 To Andy's point about what are the documents, I
4 think we've seen somewhat of an improvement, at least with
5 the official application, but I just wanted to note that we
6 recently had an incident -- and I think it was in Arizona,
7 if I'm remembering correctly -- where the waiver amendment
8 was submitted, and the precise waivers requested were not
9 clear. So we actually raised an objection with CMS about
10 that and said they shouldn't have certified it complete,
11 because if nothing else, we need to know what states are
12 requesting specifically with respect to waivers, and they
13 did pull it back for a little while. But, anyway, I would
14 just encourage you to look at that.
15 Secondly, I think the evaluation question is
16 absolutely vital, and I've heard many, many stories about
17 state evaluations. If the evaluator is picked by the
18 state, funded by the state, unfortunately I've heard far
19 too many stories about good research that's suppressed,
20 things that don't get out. And I think we're seeing right
21 now a pretty high profile battle that has just emerged,
22 perhaps the first time a governor is actually engaging on

1 this particular issue with Governor Pence, who is objecting
2 to the federal evaluation. And particularly as states push
3 for replication, as Chuck mentioned, and relying on sort of
4 a proven track record, well, what is the proven track
5 record if it's your own evaluator that you've picked and
6 paid? So I'll leave that at that.
7 And then the other issue that Sara raised about
8 is it a meaningful public comment process I think is also
9 very important. I believe the regulations do require
10 states to actually report in their applications as to what
11 they've heard and kind of sum that up and how they
12 responded. But when you read the applications -- and they
13 will typically attach an appendix with lots and lots of
14 public comments and sometimes summarize those. But it
15 would be wonderful -- and I'm hoping maybe GAO will do this
16 or perhaps MACPAC could do this -- to do some kind of
17 analysis of what actually changed in the application. I
18 have seen quite a few instances where states close their
19 public comment period. They revise their applications
20 within 24 hours. And the worst example I can think of is
21 one state changed seven words after the public comment
22 period in a 100-and-something-page document, and revised it

1 in 24 hours.

2 So getting a sense of that, sort of looking at

3 actually how much change between the application that was

4 put out for comment and actually ultimate application

5 submitted would be very interesting.

6 Thank you so much.

7 CHAIR ROWLAND: Thank you. Okay. We will now

8 take a break and reconvene at 1:15.

9 * [Whereupon, at 12:03 p.m., the meeting was

10 recessed, to reconvene at 1:15 p.m., this same day.]

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1 AFTERNOON SESSION

2 [1:20 p.m.]

3 CHAIR ROWLAND: If we could please reconvene.

4 As all of the Commissioners know, we have been
5 looking at various issues around the behavioral health
6 population within the Medicaid program, around some of the
7 models for behavioral health integration. We had a panel
8 previously, and now Katie has put together draft chapter
9 that we would like to be able to include in our March
10 report, so I'm going to ask Katie to take us through some
11 of the basics of the chapter and then open it up for
12 discussion to the Commission reviewers and then to the
13 Commission members.

14 **### Review of Draft March Report Chapter on**
15 **Behavioral Health Integration**

16 * MS. WEIDER: Thank you, and good afternoon. So,
17 again, the plan today is to provide an overview of our
18 draft chapter on behavioral and physical health integration
19 in Medicaid. But, first, I'll provide a quick overview of
20 the Commission's past work on behavioral health.

21 In our June 2015 report, we had a chapter
22 focusing on the prevalence of behavioral health conditions

1 in the Medicaid population, as well as enrollee use and
2 expenditures of behavioral health services. Following that
3 chapter, we contracted with the State Health Access Data
4 Assistance Center, SHADAC, within the University of
5 Minnesota to conduct a scan of state-level Medicaid
6 programs, focusing specifically on the integration of
7 physical and behavioral health. This catalog was reviewed
8 during our September Commission meeting in which we also
9 had a panel presentation focusing on models of behavioral
10 health integration, as well as challenges within the
11 Medicaid program in implementing an integration effort.
12 Building from our past work and discussions, we
13 now have a chapter on behavioral health integration. Just
14 to highlight some key points and next steps about the
15 chapter, it's intended for our March 2016 report. Second,
16 it highlights major themes that were discussed in our past
17 work, which I'll get into in more detail in my upcoming
18 slides. And, third, it does not include recommendations.
19 The goal of our discussion today is to complete
20 our public work on the chapter. If the Commission has
21 specific comments, please raise them today or you can also
22 send them to us.

1 So the structure of the chapter is presented in
2 four major sections that I've outlined here. I'll discuss
3 each section in more detail, but major themes from the
4 sections include that integration is influenced at the
5 clinical, payer, and administrative levels. This has led
6 to a variety of initiatives working to integrate physical
7 and behavioral health within the Medicaid program.
8 Additionally, focusing attention on integrating care for
9 dually eligible beneficiaries has also driven integration
10 of behavioral and physical health. However, the ability to
11 implement integration efforts has been prohibited by policy
12 and practice barriers.
13 So now to provide more detail on these sections.
14 The first section prevents three levels of
15 behavioral and physical health integration. That's
16 clinical, payer, and administrative.
17 Clinical integration refers to efforts providers
18 can take to change the focus of care delivery from single
19 episodes of treatment to a comprehensive approach in which
20 services are delivered in a consistent and coordinated
21 manner with accountability for health and costs. This can
22 be accomplished through collocation of providers, data

1 sharing, and provider training initiatives, just as some
2 examples.
3 These efforts can facilitate patient referrals
4 and follow-up, foster collaboration across systems, and
5 connect beneficiaries to needed resources. However, there
6 is no one model of clinical integration or sets of core
7 features that will guarantee improved care delivery.
8 At the payer level, we have multiple government
9 agencies, including state mental health agencies, SAMHSA,
10 criminal justice, and school systems, often involved in the
11 financing and delivery of behavioral health services.
12 These multiple sources of financing create a patchwork of
13 programs that either work in concert or in conflict to
14 deliver behavioral health services.
15 At their best, these programs often fill in each
16 other's gaps or can be used to maximize funding available
17 for behavioral health services. However, these multiple
18 funding sources often have their own provider networks,
19 eligibility systems, billing procedure, and rates. Even
20 within Medicaid, a state may behavioral health services
21 through a combination of fee-for-service and managed care
22 payment approaches, and also through multiple waiver and

1 state plan authorities. These differences in purchasing
2 models may limit the ability for states to completely blend
3 funding streams.
4 In addition to funding, other state agencies play
5 a large role in the administration of behavioral health
6 services for Medicaid beneficiaries. State Medicaid
7 agencies have ultimate authority over all state Medicaid
8 services, but they can delegate program functions to other
9 entities. Delegating authority and oversight to other
10 agencies with differing missions, leadership, and expertise
11 can make it difficult to integrate services under one
12 organization or hold any one actor accountable for
13 outcomes.
14 Additionally, in many states Medicaid and
15 behavioral health agencies are separate entities. These
16 agencies can be located in different departments or located
17 as two separate agencies under the same umbrella
18 department. However, some states are addressing these
19 concerns by consolidating agencies and developing
20 relationships to reduce administrative conflicts.
21 From this, we see the ability to integrate
22 physical and behavioral health is dependent on clinical

1 payer and administrative levels. As a result, there is
2 tremendous variation in the approaches state Medicaid
3 programs can take to integrate physical and behavioral
4 health care.

5 The chapter describes these varying approaches by
6 first discussing findings from the SHADAC report and
7 including a summary of the SHADAC catalogue in its
8 appendix. The chapter also documents four models that
9 Medicaid programs use to integrate care, which include:
10 one, comprehensive managed care; two, accountable care
11 organizations; three, health homes; and, four, primary care
12 case management.

13 Within comprehensive managed care, states are
14 increasingly moving towards carve-in models, meaning a
15 single state managed care entity holds financial and
16 administrative responsibility for both behavioral and
17 physical health services. Carving behavioral health in to
18 a primary Medicaid managed care contract centralizes
19 accountability, quality, and cost within one organization.

20 However, some states are unable to carve
21 behavioral health services into primary Medicaid managed
22 care contracts due to financial constraints, policy

1 restrictions, historical precedent, and stakeholder
2 opposition. As a result, states carve behavioral health
3 benefits out of primary Medicaid managed care contracts and
4 work separately with a specialized provider network or
5 another managed care organization to provide these
6 benefits.
7 However, carve-out models have their
8 disadvantages. Behavioral health carve-outs can lead to
9 segmentation of care, poor care coordination, restrictions
10 in choice, and disruptions in continuity.
11 The second model highlighted in the chapter are
12 health homes. States are increasingly using health home
13 models to integrate physical and behavioral health. The
14 program provides flexibility for states, allowing them to
15 create health homes specific to individuals with behavioral
16 health disorders. As of October 2015, 19 states and the
17 District of Columbia had a total of 27 approved Medicaid
18 health home models that served over 1 million Medicaid
19 enrollees. Of these 27 health homes, 12 were specifically
20 targeted to mental health or substance use population.
21 The third model reviewed in the chapter is
22 accountable care organizations. States have the

1 opportunity to use ACOs to encourage behavioral health
2 integration by including behavioral health services in ACO
3 payment and also requiring ACOs to utilize behavioral
4 health providers.
5 And, finally, the chapter discusses primary care
6 case management models. There are a few models of primary
7 care case management that focus on integrating physical and
8 behavioral health, but under this model, states can pay
9 primary care providers enhanced fees to perform particular
10 integration activities, such as collocation of providers,
11 in addition to a fee-for-service payment for delivery of
12 health services.
13 One of the major drivers of integration is the
14 dually eligible population. Dually eligible beneficiaries
15 account for a disproportionate share of Medicare and
16 Medicaid spending. Their high costs are associated with
17 complex health needs, which include a high prevalence of
18 behavioral health disorders.
19 Several initiatives are underway to the align
20 Medicare and Medicaid programs as well as care delivery for
21 dually eligible beneficiaries. These initiatives include
22 the Financial Alignment Initiative, also known as the

1 "duals demo," dually eligible special needs plans, D-SNPs,
2 and also the PACE program. These initiatives have the
3 opportunity to fully integrate the delivery of behavioral
4 health services while aligning Medicare and Medicaid's
5 financial and administrative structures.
6 There is evidence to suggest that integrating
7 behavioral and physical health can be effective at
8 improving care and controlling costs, and an increasing
9 number of programs are working to do so. However, these
10 programs are far from universal. Legal, administrative,
11 and cultural barriers often impede integration efforts.
12 Here we have listed the barriers that are
13 highlighted in the chapter. The chapter really discusses
14 these barriers at a high level, and future work can develop
15 a deeper examination of these issues.
16 In closing, the chapter highlights that
17 integration of physical and behavioral health care can play
18 a role in improving care for a high-cost, high-need
19 population. As we have demonstrated today, behavioral
20 health integration within the Medicaid program is not
21 defined by one model. However, the spectrum of integration
22 models, research gaps, and limited quality measures on

1 behavioral health outcomes make it difficult for
2 policymakers and program administrators to determine which
3 model or which hybrid of models can best meet their needs.
4 Additionally, the ability to use behavioral
5 health integration as a mechanism to improve care and
6 reduce costs is often limited by policy and practice
7 barriers. The themes highlighted in this chapter lay
8 groundwork for our future work, specifically as we plan a
9 roundtable examining how to improve delivery of behavioral
10 health services in Medicaid.
11 With that, I look forward to your comments, and
12 we can begin today's discussion.
13 CHAIR ROWLAND: Thank you. I'm going to turn to
14 Donna, then Peter and Norma for opening comments.
15 COMMISSIONER CHECKETT: Thank you, Katie. It is
16 a really important topic, and I really appreciate the
17 evolution of this from our earlier work this year.
18 I have a few comments, and I'll start with just
19 maybe a couple that are more, I think, things we want to
20 look through as we do a final review of the chapter.
21 I felt at times that we were blurring behavioral
22 and physical health integration at the provider level with

1 that at the payer level, and I've got a couple instances
2 that I can show you later, because something that is true
3 or an issue at a provider level isn't an issue at a payer
4 level. And I also noted, for instance, the title is
5 "Integration of Physical and Behavioral Health Services,"
6 but a lot of times throughout the chapter we are talking
7 about behavioral health services, and to me, integration of
8 behavioral health services, and I think we want to just
9 make sure that we keep going back to we're talking about
10 integrating physical and behavioral health services. So
11 just to make that clarity as we're describing it because,
12 otherwise, just behavioral health integration, I think we
13 know what it refers to, but it's really not as clean as if
14 we would say we're talking about physical and behavioral
15 health integration.
16 And along those lines, in the first page, when we
17 give a definition of the term behavioral health integration
18 -- and I think this is what caught my attention -- it
19 really refers to provider in the second paragraph, and it
20 completely leaves out where, you know, a lot of the
21 discussion is about really making sure that -- or not
22 making sure, but states that are having efforts to move

1 away from behavioral health carve-outs and the integration
2 at the payer level. So, again, I think just being really
3 sensitive to that, and I'm not sure that that definition is
4 really appropriate there.
5 On page 12, there is a reference -- and Sara can
6 probably give us the exact date, but we talk about states
7 contracting with managed care organizations in the early
8 1990s, and some of us are at least old enough to know that
9 I think it might be like the late 1970s or the early 1980s
10 when MCOs started. So Sara will give us the correct date.
11 It was '76? '68? Oh, my God. You probably weren't born
12 then, Katie, and that's why you didn't know that.
13 [Laughter.]
14 COMMISSIONER CHECKETT: I'm not taking a poll of
15 the rest of the Commissioners, but some of us can talk
16 about where we were when Kennedy was shot. I just heard
17 about it. That's right.
18 But probably my more significant discussion or
19 concerns are on page 13 where we talk about the successful
20 -- carving behavioral health services into a comprehensive
21 managed care contract does not guarantee successful
22 integration. And my question was, you know, I don't know

1 what successful integration is yet, and I don't know that
2 anyone does, although people have ideas, and I think it's
3 actually a lot of early work that's interesting and
4 important being done. But we go on to say -- and I
5 actually, with Anne's help and probably yours, I went and
6 actually looked at some of the sources, because the report
7 goes on to say that -- to talk about this -- a perception,
8 I would use the word, that when managed -- physical and
9 behavioral health are put together, that behavioral health
10 services are going to be decreased, utilization will be
11 decreased because the payer is going to be incentivized to
12 move those funds to physical health. And it caught my
13 attention because that is something that I think has been
14 around for a long time. I think that it is probably a view
15 -- I don't think. I know it is a view that is still held
16 by stakeholders. I don't think there would be unanimous
17 agreement that that actually is the case or even, frankly,
18 in a day of such oversight and, you know, payers' use of
19 national guidelines on clinically based evidence that, you
20 know, you really just can't deny services for the heck of
21 it anymore.
22 So I would feel comfortable with this language

1 staying in as long as we're really clear that -- and I
2 think when you look at the source, it's a stakeholder
3 concern. So I think if we want to say, you know,
4 stakeholders have this issue, I would be fine with it.
5 But, otherwise, because what I didn't like about
6 it is I just think we've moved so far from that debate, I
7 want to make sure the Commission isn't perpetuating it.
8 But I understand it's a real issue for other people.
9 I guess so that I don't talk too long, the only
10 other -- I guess I would go back to when we look at the
11 barriers, that the barriers are really very focused on
12 providers, and I think there are some significant barriers
13 to payer integration, and those are largely political and
14 sometimes legislative that keeps states from moving forward
15 with integration.
16 I do think that it astonishes me the speed at
17 which at the payer level -- and I can't speak to the
18 provider level because that's not my expertise, but the
19 degree -- how quickly states are moving to integrate
20 physical and behavioral health is really pretty incredible.
21 And so whether we want to, you know, make an update on
22 that, how many states are moving toward that, or certainly

1 at least under the barriers, we need to speak to provider
2 and payer.
3 And then, last, there is a statement that says
4 many states do not cover substance abuse services under
5 Medicaid, and I actually didn't know if that was true or
6 not. But I would be open to that if others, I guess -- I
7 don't know if it's true.
8 EXECUTIVE DIRECTOR SCHWARTZ: I don't have the
9 data right here at my fingertips, but we've been actually
10 working on a brief that documents covered services. So we
11 can use some of the information we have from that brief--
12 COMMISSIONER CHECKETT: Okay.
13 EXECUTIVE DIRECTOR SCHWARTZ: -- that we used
14 from state plan documentation to make sure that people have
15 confidence in that statement.
16 COMMISSIONER CHECKETT: Well, or, you know, it
17 might be that it's like the SAMHSA money instead, and so
18 that's why I just said I'm just not really sure. But I
19 just wanted to --
20 COMMISSIONER ROSENBAUM: For the expansion
21 population, of course, it's a required service, although it
22 may be very limited in its coverage.

1 COMMISSIONER CHECKETT: Right.

2 COMMISSIONER ROSENBAUM: But for the traditional
3 population -- first of all, this particular group would
4 have been very small in the traditional population, and to
5 the extent that they are present in the traditional
6 population, you could in theory cover rehab services that
7 didn't include broad substance abuse services.

8 COMMISSIONER CHECKETT: Right, yes.

9 CHAIR ROWLAND: Wasn't there at one time also a
10 provision that if that was your only diagnosis, you
11 couldn't qualify?

12 COMMISSIONER ROSENBAUM: That was [off
13 microphone].

14 VICE CHAIR GOLD: Yeah, I mean, I noticed that
15 too, and I think part of it's just making sure that it's
16 clear why it is. I mean, is it an optional benefit or how
17 does the lack of coverage come about and what are you
18 talking about?

19 COMMISSIONER CHECKETT: Or I think it might be
20 SAMHSA funding, too. So, anyway, I told Anne when we
21 talked at lunch, I just have been working a lot on this
22 issue myself, and so I really did enjoy reading it. But I

1 probably had a little bit too much of an eagle eye on it,
2 too, saying, like, "Are you sure about that?" But it's a
3 really great work, and it's such an important topic, and so
4 I'm really glad that the Commission is working on this and
5 will continue to be working on it as well.
6 Thank you.
7 COMMISSIONER SZILAGYI: I want to echo a lot of
8 what Donna said. It's a really good chapter. I thought it
9 was very challenging to write from my perspective. I think
10 the organization is really good.
11 The big challenge, in my mind, is that there are
12 almost no outcomes presented in the chapter. So are any of
13 these models, or are any of these different structural
14 arrangements effective. And do they increase or reduce
15 costs, or stay the same?
16 And, you know, I actually felt the same when we
17 heard the SHADAC presentation to us, which was -- so I
18 would probably set this chapter up as this is a descriptive
19 chapter describing what is out there.
20 And I would push us a little harder to work with
21 consultants, and I don't know whether it's in the format of
22 some boxes where we can demonstrate small examples where

1 people have rigorously studied integration in some ways and
2 it has shown an effect on A, B, and C, or has not shown an
3 effect, and has increased costs or has decreased costs.
4 I sort of felt that, you know, the chapter is
5 really great descriptively, and it kind of left me a little
6 bit unsatisfied not because of your work but because
7 probably where the evidence is, that it just wasn't clear
8 whether any of these models work or not.
9 So when we send this out for consultations, I
10 think there may be some -- there are examples. Asarnow's
11 work is an example where it's very small. It hasn't been
12 implemented across an entire state. But they did find an
13 impact on very specific outcomes, and they did look at
14 cost.
15 So maybe showing them in boxes or -- so that's
16 one comment.
17 I think in the introduction part I would suggest
18 a little bit more writing on: What problem are we trying
19 to overcome. Why are we trying to --
20 UNIDENTIFIED SPEAKER: Why do we care?
21 COMMISSIONER SZILAGYI: Why do we care about
22 integration? And so that also leads, you know, to the

1 outcomes. Okay, so point said.

2 Under strategies for integration, there's one
3 type of model -- and I don't even know what kind of model
4 to put this under -- which I didn't see in here, but I may
5 have missed it, and it exists in both New York and
6 Massachusetts, which is kind of a combination. In New
7 York, it's called CAP PC. In Massachusetts, I don't know
8 what it's called.

9 But it's where primary care providers have a
10 formal -- they get formal training, and then they have
11 formal consultation from behavioral specialists about
12 specific patients and specific cases. So it's kind of a --
13 it's not only on primary care. It's not only on specialty.
14 But it is classic integration, and it tries to deal with
15 the issue that there's too few behavioral and mental health
16 specialists out there to help the primary care practices.
17 Primary care practices have to take more of it on.

18 And so you may want to mention that as sort of an
19 example, but again, I don't know whether they have outcomes
20 either.

21 And I really liked, and I would suggest maybe
22 expanding, the barriers section because I think that may be

1 areas where we could actually try to eventually, as a
2 country, intervene. Do something about it. So I really
3 liked the way you laid it out.
4 And you may think about whether or not it
5 foreshadows future chapters or within this chapter, whether
6 we could go a little further with the barriers. Okay,
7 these are the barriers. What are some potential options?
8 Not necessarily giving a recommendation for where to go,
9 but what are some potential options, so expanding the
10 barriers part because that's where I was left -- you know.
11 We're all problem solvers and trying to solve the
12 problems. The barriers laid out some specific areas where
13 we can solve the problems.
14 COMMISSIONER MARTÍNEZ ROGERS: I thought that it
15 was a really good chapter, Katie, but it's a lot of work,
16 and it's such a complex picture.
17 The only comment I really have in terms of the
18 chapter is based on what Donna and Peter were saying. One
19 thing that struck me, and I mentioned this to Donna, is
20 that I don't think -- when you talk about children on page
21 two, I just wonder. You know.
22 Are we talking -- because most of it seemed to be

1 geared towards adult integration. Are we not looking at
2 what pediatricians or where children go to see doctors?
3 Because there is a tremendous problem in behavioral health
4 with children and adolescents.
5 And if we're integrating that, do we want to say
6 a little bit about that? You know.
7 I notice that you mention PACE, you know, for the
8 elderly. But are there any strategies or any programs or
9 anything geared towards physicians who treat children and
10 the others?
11 And Peter has brought this up several times -- is
12 the issue of foster children. Is that going to be a
13 totally separate chapter, someplace else? Or, how are we
14 going to address some of those issues, or is it just making
15 it too cumbersome?
16 That was the only thing that -- I've worked a lot
17 with children and adolescents, and I guess that's why I
18 kind of looked at it and was thinking, okay, because we're
19 looking more and more at 11-year-olds becoming heroin
20 addicts, substance abuse. And I'm wondering if we're going
21 to say anything about some of those areas.
22 MS. WEIDER: It's something we can expand upon in

1 the chapter.

2 COMMISSIONER GOLD: Or, say it's not there

3 because we didn't do it.

4 MS. WEIDER: Yeah. Some of the health home

5 models focus on children, but the research is limited on

6 integration models for children and adolescents.

7 CHAIR ROWLAND: Well, certainly what we saw with

8 the foster children was the high use of psychotropic drugs.

9 So, clearly, there -- you know. If one wants to do sort of

10 a deep dive on one population with very large behavioral as

11 well as physical needs, it would be to look through the

12 lens of the foster care.

13 Okay, I have Mark, Sara, Patty, Chuck, Sheldon.

14 COMMISSIONER HOYT: So I don't know if it appears

15 in this chapter or not, or if it's just me. Most of the

16 discussions I ever got involved in here got into pharmacy

17 pretty early on, and I didn't see any mention of that in

18 here. If it just doesn't fit in this chapter, then I would

19 still mention that you're going to look at it later or

20 something.

21 But, you know, specifically putting together the

22 appropriate database that the right people have access to

1 from either side, to see everything that's being prescribed
2 and then the financial responsibility for the drugs. I
3 don't know if that still varies some, state-to-state. If
4 it's carved out, you know, how do you parse that out?
5 CHAIR ROWLAND: And who prescribes those drugs.
6 Sara next.
7
8 COMMISSIONER ROSENBAUM: Just a couple of things.
9 It was a great chapter.
10 The privacy and data-sharing paragraph on page
11 22, you might want to note that the same issues that arise
12 with exchange of data because of federal law often arise
13 under state law, that many states have put restrictions on.
14 And so you know, even where there's no federal law
15 prohibiting the exchange of mental health information as
16 opposed to addiction information, or substance abuse
17 information, in fact, you can't do it under state law,
18 which is, you know, an issue to be tackled.
19 The other problem I wanted to flag was that we
20 mentioned licensing requirements and we mentioned workforce
21 requirements. There's another issue going on right now
22 that I think maybe merits its own bullet, which is -- and

1 it goes back to the issue of providers. It is the problem
2 of providers attempting to scale up to become these things.
3 Okay? To become providers that can essentially manage
4 complex patients better.
5 And, of course, the two models that are being
6 used are you start with a provider that is, quote/unquote,
7 a physical health provider and it adds capacity, or you
8 start with a provider that's a behavioral health provider
9 and it adds capacity. And the capacity may be onsite. The
10 capacity may be an affiliation. You know, a formal
11 affiliation with another provider.
12 But I think that it's been very slow going. So,
13 for example, we've noticed over the years from community
14 health center research that whereas health centers scaled
15 up quite rapidly on mental health, way behind on addiction,
16 and that for that reason HRSA put addiction money of the
17 new expansion money -- I think they just put $100 million
18 out there just to add addiction capacity.
19 And I know on the other side there's been the
20 same struggle, which is you have providers that began their
21 lives as mental health centers trying to grow into being
22 full-blown, say, community health centers, running into

1 trouble.

2 And so this issue of how exactly -- and it sort

3 of goes to all the earlier points. You know. How you add

4 this capacity and what the mechanics are of growing a

5 capability, of being able to do the service that's expected

6 to become a -- well, we keep saying it's a health home.

7 But we sort of need to scratch the surface of

8 that a little bit more, to say it's very hard actually to

9 become one of these things, and because it's hard to become

10 one of these things, it's very hard for any superimposed

11 financing system to get a lot of traction going if you just

12 don't have any supply of providers doing complex work.

13 CHAIR ROWLAND: Patty.

14 COMMISSIONER GABOW: Well, I agree with a lot of

15 what's been said, especially how important this issue is.

16 And my first comment is I really do think that

17 more attention about framing it from the start, maybe even

18 a brief review of our other work that led us to look at

19 this, maybe a page -- it doesn't have to be volumes -- and

20 what is the argument for integration. I do think setting

21 this up a little more would be useful.

22 And in the argument for integration on the first

1 page, one of the things we say is that it's a means to
2 provide more cost-effective and improved outcomes. I think
3 we should add it's also more patient-centered because the
4 idea is that we're asking the most vulnerable people to
5 navigate two dysfunctional systems or, in the case of
6 substance abuse, three dysfunctional systems, when they're
7 the most vulnerable. So I think putting some of this back
8 onto the "We're also doing this for the person who has
9 these things altogether in themselves as a human being, not
10 in silos." So that's one thing.

11 I really strongly agree with this idea of trying
12 to put in some -- and I like your boxes idea -- some
13 examples of outcomes because there are some. I mean,
14 they're not going to win Nobel Prizes in terms of the level
15 of research, but you know, just to give us some directional
16 thought about where it might be. For example, I do think
17 that you mentioned the Hennepin County Ambulatory Intensive
18 Clinic, and I think they have some data, and it's
19 interesting data. So I think some examples that might
20 point us to directions would be useful.

21 My next to the last comment is about the
22 barriers. I think sort of elucidating a little bit more on

1 these barriers, why they came about, like the billing
2 restriction. I mean, what you say is it was designed to
3 reduce inappropriate billing, but that sort of doesn't tell
4 me really why that was -- I mean, was it just done to save
5 money?
6 I mean, if you're seeing a patient for two
7 different things by two different providers, what was
8 inappropriate?
9 So I just think a similar thing about providers'
10 inability to bill Medicaid tells us that they're
11 restricted, but I suspect it's the, you know, various
12 groups are wanting someone else in the barn. But it would
13 be useful to talk about those.
14 And if we have any idea -- and maybe there's no
15 data out there. If you could, which of these barriers
16 would be the most important to try to start -- where to
17 start removing? Would it be the same-day billing? I don't
18 know if there is some direction that could help us sort of
19 say, of these barriers, maybe the most fertile one to start
20 looking at would be X.
21 And my last comment is I think we should give
22 some thought, and I don't have a suggestion, about how to

1 make the conclusion a little more hard-hitting and a little
2 more focused about sort of what are the most important
3 areas to look at research-wise, what are the most important
4 areas to try to come to -- what are the really solid, most
5 important next steps, or something. But it's a complex
6 chapter with a lot of information and facts. So I think if
7 we could try to pull it together in some more robust way at
8 the end it would be very useful to the reader.
9 Thank you.
10 COMMISSIONER MILLIGAN: Katie, I think you are
11 hearing from all of us that we're glad we didn't have to
12 write the draft.
13 My main comment, and I've got some examples, is
14 that there is, I think, a tenor that integration is a good
15 thing, and I think that's true generally, and I think it's
16 certainly the trend.
17 But when I was in Maryland I led a very extensive
18 stakeholder process, personally led a lot of meetings that
19 resulted actually in more of a carve-out model. And it
20 wasn't necessarily because of barriers. It was because, I
21 think, for Maryland it was the better policy.
22 So I want to give some examples in a second, but

1 I guess the main point I want to make is that there is a
2 sensible outcome for a state to have a carve-out model. I
3 think that there has to be space in the chapter for there
4 not to be too much of a normative statement.
5 I work now in a state that has an integrated
6 model, and it works for that state better that way.
7 So let me really quickly touch on the points for
8 Maryland. When I started the stakeholder process, SUD
9 services were carved in, and mental health was carved out.
10 And so there was a -- within BH, there was already a lack
11 of integration.
12 We did a stakeholder process. The outcome was to
13 carve SUD out and do a single carve-out kind of
14 arrangement.
15 The main factors that drove that decision were --
16 I want to just list a few just to kind of illustrate. And
17 there's a 30-page document I wrote about that was public,
18 about 3 years ago, about why we made those decisions, but
19 one was we had a whole bunch of MCOs.
20 There were eight MCOs, and a lot of the mental
21 health providers that had been in a carve-out forever
22 because it had never been carved in would not have been

1 prepared to sort of deal with eight MCOs, credentialing and
2 contracting claims, all that stuff. So part of the context
3 is, you know, the MCO environment.
4 In Maryland, dual eligibles are not part of
5 managed care at all. They're still fee-for-service on the
6 Medicaid side. And so if you carve in behavioral health
7 but 50 percent of the people who utilize the benefit are
8 duals, the state still has to run a carve-out anyway
9 because you've got a whole boatload of people who aren't
10 fee-for-service -- the duals. And so you can solve the
11 problem for some people but not for a lot of other people.
12 A third factor was there was very little overlap
13 between the plans that were listed on our exchange and the
14 plans that were in Medicaid managed care. The dominant
15 player in commercial insurance in the exchange is
16 CareFirst, which is the BlueCross plan, which doesn't
17 participate in Medicaid, and it's probably 80 percent of
18 the market share in commercial in the exchange. The
19 dominant three of the big four in Medicaid were not on the
20 exchange. And so there was going to be churn, and we
21 thought it would be cleaner for there to be a single
22 administrator of a BH benefit for working through

1 continuity of care back and forth with the exchange because
2 it wasn't eight MCOs mapping to three QHPs with no overlap.
3 And there are other factors that I don't -- you
4 know, I could go into, and it's in the document. But my
5 main point is that there can be a sensible reason to do a
6 carve-out.
7 And I guess one last point that I don't want to
8 forget. When you talk to people in the stakeholder side of
9 BH, or at least many of the people who participate in our
10 meetings, they think of integration differently than we
11 talk about integration here. We talk about integration
12 really from a physical health/behavioral health point of
13 view and sometimes to include LTSS. They talk about
14 integration with social services, about homelessness,
15 housing, jobs, education, criminal justice, the social
16 determinants.
17 And where a lot of people with profound BH needs
18 have their highest concerns are often housing, criminal
19 justice, jobs, employment.
20 And the point that was made repeatedly in
21 Maryland was if you have eight MCOs and you carve this
22 stuff in, they do not -- they do not collectively have that

1 expertise that you would find with a single vendor that
2 you're monitoring to track how many people. And your
3 metrics and your outcomes repeatedly, for me, were less --
4 what I heard was less about avoid all ED associated with,
5 you know, self-harming behavior, but it was more about what
6 percent of the population has a roof over their head and
7 those kinds of metrics.
8 So I've taken too much. My main point is have
9 room in your description for the validity of a carve-out
10 from a policy point of view given the state context.
11 CHAIR ROWLAND: Chuck, can you make available the
12 report you did all those years ago?
13 COMMISSIONER MILLIGAN: I can. It's on the
14 website but you'll never find it there, so I'll send it to
15 you.
16 CHAIR ROWLAND: That's why I'm asking.
17 MS. WEIDER: I found it once and then I never
18 found it again. I tried to go back and find it a second
19 time.
20 COMMISSIONER MILLIGAN: I'd be happy to send it.
21 CHAIR ROWLAND: Because I think those are very
22 important points and they really go to the decision-making

1 process that has to go on, and especially the point about
2 the need to integrate with social services, because that's
3 where this population often needs more help than they do on
4 some of their fiscal issues.
5 Okay. I have Andy, then I have Trish and Sharon.
6 COMMISSIONER COHEN: Great discussion. I agree
7 with so much of it.
8 CHAIR ROWLAND: Oh, I missed Sheldon. He was
9 supposed to go before you, Andy.
10 COMMISSIONER COHEN: I will just say, as a funny
11 point, and I won't be as effective or comprehensive as
12 Chuck was, but New York had almost all the same factors
13 that Chuck described and decided to go for an integration
14 model. The one difference is that there is much more
15 overlap between the Medicaid plans and the exchange plans,
16 but everything else had the factors and decided to go
17 integration. But it's a good point. I mean, there are
18 pros and cons.
19 My big picture point about this, which has been,
20 I think, sad but I'm just going to say it in a slightly
21 different way. Integration is not an end in and of itself.
22 Patient-centeredness and addressing the whole patient is

1 the end. Integration is a means. Integration -- it is not
2 apples to apples to say clinical integration,
3 administrative and financial integration. The integration
4 that interacts with the person is usually clinical, you
5 know, and there's lots of models, and there's lots of
6 research, and I don't know if you captured it all.
7 But I have an instinct that maybe there is more
8 out there about sort of outcomes on clinical integration,
9 and just because we don't have great outcome measures on
10 behavioral health, a lot of the impact is people with
11 serious behavioral health issues having very poor outcomes
12 on physical health stuff, and I feel like that's mentioned
13 in one little place but not really given very much
14 attention.
15 I mean, the paper, that's something I think you
16 could beef up and I think there actually is some more
17 research on, but to me, administrative and financial
18 integration are sort of facilitators to the sort of more
19 patient-centered approach. So it's sort of how do you make
20 the system be more patient-centered, and one way to do that
21 is to sort of integrate at an administrative level, or a
22 financial level, or otherwise.

1 So I kind of feel like it doesn't make sense to
2 me to sort of them seem like they're parallel or apples to
3 apples. Like clinical integration is one way to go at it
4 and administrative -- you know, these are maybe things that
5 different states have done but that's not really -- they
6 sort of aren't coherent to sort of treat them as like equal
7 things. So that's one point. And I already made the point
8 about the physical health sort of results I think maybe
9 being somewhat more, sort of accessible but also a point
10 that needs a little bit more attention.
11 My third point, which again maybe has been made
12 before but I just want to emphasize it -- so I did notice
13 New York is going through a massive, you know, sort of
14 integration effort affecting hundreds of thousands of
15 people where some people with serious -- some people with
16 behavioral health conditions, all their services are
17 getting carved into mainstream managed care and people with
18 really serious issues are being addressed in specialized
19 plans that are integrated. They're all behavioral and
20 physical health issues addressed in one plan that's sort of
21 carved out for a really serious population.
22 You know, it doesn't show up in any of the

1 charts. It doesn't show up in here. I understand why,
2 because you had a time frame that you were looking at. But
3 I think maybe it misses -- you were sort of saying there is
4 this trend, there's all this action, and I don't think this
5 reflects that so well, because a lot of the stuff that's in
6 the charts are about, like, small pilots and, you know,
7 sort of little things, and since the time frame that was
8 identified there has been much more action and trend in one
9 direction. So I think it's important that the paper kind
10 of reflect that, even if you don't have the specific
11 examples because the research had a time frame, to say
12 that, you know, in a paragraph or so, three more big states
13 have done X, Y, or Z.
14 So those are my comments, and thank you.
15 CHAIR ROWLAND: Sheldon.
16 COMMISSIONER RETCHIN: I was going to echo what
17 Donna said at the beginning, and then Chuck destroyed
18 everything I was going to say.
19 [Laughter.]
20 COMMISSIONER RETCHIN: I thought it was a
21 terrific effort. The confusion I had, as well, is whether
22 the integration is meant to be at the MCO level or at the

1 provider level. But let me just sort of tell you from a
2 provider level why I do think it's important, because I
3 think the seams actually stifle innovation.
4 So you have a patient who comes in, is enrolled
5 in an MCO, but comes in for major depression or
6 schizophrenia in an emergency room, you would like a
7 provider that would then work with the MCO to present an
8 innovation where you would hold a patient somewhere in a
9 non-admission, an observation unit, lower cost, stabilize
10 the patient, and get them out. But actually the MCO --
11 we'll call it the physical MCO for lack of a better term,
12 is completely uninterested in that. They would like
13 nothing better than for the patient to be admitted in an
14 inpatient psych unit and flip out to the carve-out. So I
15 do think that that scene is preventing innovation.
16 One more point that I was a little surprised at.
17 So the IMD exclusion, I guess you brought in as an example
18 of a barrier, which I would agree, but I worried that the
19 opposition to reversing the IMD exclusion would actually be
20 for the very reason that it's more difficult to integrate
21 physical and behavioral health in some of the IMDs, because
22 they're standalone psych hospitals. That's why I

1 personally think the more important integration is really
2 at the payer level, where you can get innovation, and it
3 doesn't really matter if somebody needs an inpatient bed.
4 We need to do away with the IMD exclusion because we are
5 absolutely not taking advantage of many beds out there for
6 communities that over-bedded on behavioral health, but are
7 not able to access the inpatient stays.

8 CHAIR ROWLAND: I think there is also a great deal
9 of interest in the Congress in our looking at the IMD
10 exclusion and gets asked what we're going to do about it
11 over and over, and I think it has two sides to it, but it
12 is really a topic that we're not going to solve in this
13 chapter, but that I think we really do need to put very
14 high on our resource agenda, policy agenda.

15 Trish.

16 COMMISSIONER RILEY: I also thought a really
17 robust chapter, and that you handled sort of the
18 complexities of the relationships among agencies very well.
19 But I keep coming back to what do we mean by integration
20 and how to frame it. I think, for me, integration has to
21 be at the patient level, for the patient. Does the patient
22 get all the care she needs, across silos, and then work

1 back up. For me, an integrated system of care is not case
2 management. That's a coordinated or, you know, everybody
3 has case managers and it doesn't necessarily -- the patient
4 may have five case managers for different systems of care.
5 The patient needs to know -- it seems to me the payer has
6 to fund -- how the payment source follows the patient is a
7 different frame.
8 I'm not being very articulate but in terms of if
9 you think about a plan of care across all the sectors that
10 a patient will experience who has both physical and
11 behavioral health needs, and then you work back up to what
12 kind of provider system helps that and how is that paid
13 for, it seems to me the questions that arise then become,
14 which one of these payment models support truly integrated
15 care, and integrated care for the patient, which means she
16 gets everything she needs at one stop, as opposed to, you
17 know, these sort of other structural things. It seems to
18 me if we start there then we can get some real policy
19 analysis about which of these models, both in provider
20 structure and how we pay for it, gets to the kind of
21 integrated care that we seek in these models.
22 CHAIR ROWLAND: Okay. Sharon?

1 COMMISSIONER CARTE: Thank you, Katie. This is
2 really great and thanks for taking such a strong start at
3 what seems to be one of the most complex, challenging
4 areas. I'd just like to note three things where I think
5 we could use more attention or focus. I think, yourself,
6 noted a while ago that there's like a dearth of evidence
7 about what really works for children and adolescents, and
8 I've seen that in other areas. I thought you made a
9 mention of it in the chapter somewhere but I couldn't find
10 exactly where.
11 The second area is health homes. I think we need
12 to follow very closely, in the future, what that area
13 yields, because I think it goes to the point of having the
14 patient-centered focus as the beginning, and will probably
15 help us understand more certain targeted populations that
16 have co-morbidity issues, like mental health and substance
17 use or abuse, or mental health and diabetes, or whatever
18 targeted populations get studied.
19 And then lastly, I'd just like to see more on
20 telehealth. I think that states are struggling with the
21 payer policies needed to make that really happen, and
22 particularly in FQHC settings where they're paid by

1 encounter and you have the Medicare methodology that
2 doesn't -- you know, that pays the sender site or the
3 originating site but not the primary care site, and that, I
4 think states are beginning to forge ahead anyway, but we
5 need to keep abreast of that. It's certainly going to
6 impact on the access to mental health treatment.
7 CHAIR ROWLAND: Okay. Marsha?
8 VICE CHAIR GOLD: Yeah. It was a very
9 interesting chapter and a really good discussion.
10 I think as I was listening to my reaction and
11 then listening to other people, the comment of framing and
12 trying to frame this in a way that helps is really
13 important, and I like the idea that came up where
14 ultimately what we're looking at is patients. I mean, does
15 the patient get the care they need? There's different
16 kinds of patients that have both behavioral and medical
17 needs, and there's different ways that could get either
18 more or less patient-centered or integrated as it relates
19 to them and what they need.
20 I'm still, you know, trying to work that in with
21 Chuck's comment. I mean, it seems like each state, and
22 each community, is starting out in a somewhat different

1 position. There are some barriers that are universal, or
2 pretty much so in the country, but each state provider
3 system has worked in different ways. And so some place may
4 have one strategy that's already helped in one of these
5 areas of integration or disintegration or patient-
6 centeredness.
7 And so it's not like we're going to come up with
8 the solution. There isn't a solution. What there is, is
9 different ways of changing what's on the ground now so that
10 it works better for people, and some of the things you have
11 work at different levels where there are different
12 problems. That doesn't tell you how to organize this,
13 because I think that's still an issue, but it seems to me
14 that's what we're struggling with.
15 Different examples that you have here affect
16 different parts of things. If you're administrative
17 agencies that have funding programs don't talk to each
18 other, it's more likely the funding things won't encourage
19 things. If your managed care plans aren't responsible for
20 a person, or a person of a certain type, then that may be
21 harder or less hard to do. If your providers don't know
22 how to talk or don't have the data to talk, that's other

1 issues. And then there's the whole social service side.
2 So maybe thinking of it as the particular
3 challenge -- I mean, that behavioral health is a really
4 complex topic. It's really important. It affects a lot of
5 people and the integration with medical care is important
6 and it costs a lot of dollars. We'd like it to work a
7 certain way for people but it doesn't always work that way,
8 and it works differently in different places, and what do
9 we know about both some things people have tried in some
10 ways and some reasons they might not have, and some
11 barriers.
12 That's what I think you have to struggle with and
13 figure out how to present, but I think -- I don't know if
14 people are right. I hear people saying we want to sort of
15 talk about how we improve care for people, and we don't
16 know a lot about how to do it and it won't be a single
17 answer.
18 CHAIR ROWLAND: You know, it seems to me that
19 what this discussion is saying is that the goal of
20 integration is a better integrated system of care for
21 people, and then how do we get there. And so, to some
22 extent, the integration at the payer level and the

1 integration at the state administrative level are
2 currently, in many ways, barrier to getting to where you
3 want to go, and in some other cases they may be effective
4 structures for making sure, as you cite, Chuck, in the
5 carve-out, of making sure the right set of services is
6 there.
7 So I think it's kind of a filter, Katie, that
8 maybe we can go through in this chapter, of saying the
9 framing is how do we get better care delivered to a complex
10 population that has physical needs, behavioral health
11 needs, and then I would put the societal needs, the social
12 needs, that can affect their ability to take their
13 medications when they need to, and their ability to get the
14 nutrition they may need, or whatever.
15 So I think there's a broad circle in which, if
16 you're trying to up the quality of care and the integration
17 of care for this population, and then go through kind of
18 what -- because when I look at the barriers, the barriers
19 are kind of very focused, but they are sort of subsets of
20 bigger barriers. And I don't think there's a lot of
21 reorganization to the chapter but just reframing a bit
22 throughout, I think would be very helpful.

1 Norma and then Patty.

2 COMMISSIONER ROGERS: Just a quick statement. I
3 think if you look at the social determinants of health, it
4 will encompass everything that Diane was talking about.

5 CHAIR ROWLAND: And Patty.

6 COMMISSIONER GABOW: I like what you said there,
7 Diane, and I think that if you look at -- and, to some
8 extent, Andy was talking about this too -- the payment and
9 the administrative structure versus the clinical
10 integration. And some places have started their focus of
11 integration at the clinical level. But if you do that
12 without thinking about the administrative and the payment,
13 some of these barriers will become very critical --

14 CHAIR ROWLAND: Substantial.

15 COMMISSIONER GABOW: -- and may impair the
16 effectiveness of the integration for the care of the
17 individual patient.

18 And so thinking about which things are enabling,
19 as you say, and can flow one way, I think we want it to be
20 at the patient level but sometimes it's hard to flow from
21 integrating the clinical up to making the state departments
22 work together or having a payment policy that facilitates

1 that clinical care.

2 So thinking about it in that way, as you were

3 beginning to articulate, may be very helpful.

4 CHAIR ROWLAND: And the other caution I'd give to

5 the Commission members is that I think there's a lot of

6 description out there of these models and these goals, and

7 probably far less solid research on the evidence of what

8 works and how it works. And so pointing out the need to

9 get better information and the need to really -- you know,

10 we talked earlier in the day about the goal of evaluations

11 and having evaluation material public, and so in some of

12 these models that are being funded, let's hope that the

13 evaluation will also focus on documenting some of the

14 outcomes.

15 Donna.

16 COMMISSIONER CHECKETT: Just a closing comment

17 and an observation. I think when you really step back --

18 so, 6 years ago, you know, those of us who were that first

19 year at MACPAC, this issue wasn't even like on the list.

20 It has gotten a tremendous amount of attention in recent

21 years. I was just listening to your comments, Diane, and,

22 you know, I think one thing that happened, I guess, as I

1 look at it, is there is all the super-utilizer, you know,
2 kind of buzz, and people start drilling down and going,
3 "Who are super-utilizers?" and, you know, the light's going
4 on across the nation when we start using data to find out
5 that people who are super-utilizers have, you know, very
6 large percentage have behavioral health disorders. You
7 drill in some more. Oh, wow, they're also in the ER.
8 And I think we all start going -- and we start
9 looking at the connection between people who have
10 behavioral health disorders costing more on the physical
11 side, and if you were track back, I think this may be like
12 3 years ago, and it's a fascinating observation you've
13 made, which is I think there's been a leap to assume that
14 therefore the solution is to integrate at both levels, at
15 the payer level and at the provider level.
16 And so now we're all running pell-mell, and I'm
17 right there with it because I think it's a great idea, but
18 actually probably not really based on any data in terms of
19 outcomes, and I think it really is -- if we're going to do
20 maybe a closing paragraph, because we're not going to do a
21 recommendation on it as a commission, but to really point
22 out that, you know, for once it's so early in a trend that

1 we're gathering data that could help us really be better
2 informed about this. That would really be of value.
3 But it has been interesting but it has really
4 caught fire really quickly. And really good work.
5 CHAIR ROWLAND: And I also think that we need to
6 add to the agenda looking at the IMD exclusion. We've
7 toyed with that before but it really needs to --
8 VICE CHAIR GOLD: As a separate thing.
9 CHAIR ROWLAND: Not in this chapter, but to flag
10 it in this chapter as something that we really need to look
11 at.
12 COMMISSIONER CHECKETT: I agree.
13 CHAIR ROWLAND: I'm going to add something to the
14 agenda before we take a break, which is if anyone in the
15 audience wanted to make a public comment around this set of
16 issues, we could entertain those now.
17 MR. SPERLING: Thank you, Diane. I'm Andrew
18 Sperling with the National Alliance on Mental Illness and
19 I'll be very brief, just to thank the Commission and thank
20 the work that the staff has done on this. It's very, very
21 important. And also commend Mitch for the IMD exclusion.
22 There is enormous interest and Congress backed a bill that

1 was reported from subcommittee in early November, actually
2 has some reforms to that, and there's a Notice of Proposed
3 Rulemaking that the Administration published last summer,
4 allowing for -- lifting the IMD exclusion as part of the
5 capitated Medicaid Managed Care Contract, so long as the
6 length of stay is under 15 days.
7 So there's enormous interest in this and NAMI
8 commends the Commission for moving forward on this very
9 important chapter.
10 Thank you.
11 CHAIR ROWLAND: Thank you.
12 Okay. Well, we will take a 5- to 10-minute break
13 and then be back to deal with more data on children.
14 [Recess.]
15 CHAIR ROWLAND: If we could please reconvene. We
16 are now going to continue our work on looking at the
17 analyses of options for children's coverage and what
18 children incur some of the high out-of-pocket spending.
19 These are all pieces that we are building toward having a
20 comprehensive set of background information to understand
21 the implications of changes in both CHIP and Medicaid
22 coverage in the future, and I'm going to turn to Chris

1 Peterson, as we always do, to open up the discussion. And
2 I believe we're at Tab 5.

3 **### Analyses and Updates on Children's Coverage:**
4 **Health Care Use and Conditions of Children with High Out-**
5 **of-Pocket Spending in Exchange Coverage**

6 * MR. PETERSON: Thank you, Diane. In light of the
7 two-year extension of CHIP passed earlier this year, you've
8 returned to broader questions on the future of children's
9 coverage. In the past couple meetings, we have provided a
10 variety of analyses on children and their sources of
11 coverage to help you think through the larger issues around
12 where children get their coverage, how much it costs,
13 whether it's affordable, and a number of other issues.
14 Today we have four presentations on issues
15 affecting children's coverage. The first one I'm about to
16 go through is health care use and conditions of children
17 with high out-of-pocket spending in exchange coverage.
18 Then next I'll be talking about policy issues in Medicaid
19 expansion CHIP. And then Joanne will follow, and she'll be
20 talking about the proposed rule on 2017 benefit and payment
21 parameters for exchange coverage and then Medicaid and CHIP
22 premium assistance and the basic health program.

1 So for this presentation, what I want to do is
2 first review the results briefly that were presented in the
3 last meeting, which are going to be the bulk of the chapter
4 for the March report that focused on in that meeting two
5 things: one was the average out-of-pocket spending for
6 children in separate CHIP and comparing that to what those
7 children would face in exchange coverage; and then,
8 secondly, is the question that you had in following up, and
9 that is, okay, well, what share of children would face high
10 out-of-pocket spending in exchange coverage? So we'll do
11 that, and then we'll turn to the new results that look at
12 the characteristics of those children who would have the
13 high out-of-pocket spending in exchange coverage, and we'll
14 wrap it up with your discussion.
15 So from the prior analyses, we showed yet again
16 that out-of-pocket spending in CHIP is less than what would
17 occur in exchange coverage, and you see the numbers there
18 from last time. And it's here that I want to note, since
19 our last meeting, HHS released a congressionally mandated
20 study of whether exchange benefits and cost sharing are
21 comparable to separate CHIP. That study is included in Tab
22 5A of your materials, and consistent with our findings, HHS

1 found that no exchange plans are comparable to CHIP with
2 respect to premiums and cost sharing.
3 The HHS study also looked at benefits and found
4 that benefit packages in CHIP are generally more
5 comprehensive for what they called "child-specific
6 services," such as dental, vision, and habilitation, and
7 are more comprehensive for children with special health
8 care needs compared to exchange plans. And on what they
9 called "core benefits" typically covered by commercial
10 plans, such as physician services, laboratory, and
11 radiological services, HHS found that coverage is similar
12 between CHIP and exchange coverage. And this is also
13 consistent with our prior analyses.
14 Continuing on this slide, the second point is
15 that out-of-pocket spending in exchange plans increased
16 substantially as income rises, and, of course, this is just
17 simply consistent with the income-related cost sharing that
18 exists in exchange coverage; and, finally, that differences
19 in states' CHIP income eligibility levels mean that the
20 group of children who receive CHIP's cost-sharing
21 protection is going to vary by state.
22 So that was the first part of the analysis from

1 last time, and then the second part is essentially
2 encapsulated in this table, which was showing what share of
3 children would face high out-of-pocket spending. And so
4 the top part shows you the share of children across states
5 who would have cost sharing and premiums above these
6 particular levels in CHIP. So very few children would face
7 spending in CHIP of anything above, you know, 1, 2, 3,
8 percent. And then, of course, 5 percent or 10 percent of
9 income is prohibited levels of cost sharing and premiums in
10 CHIP, so there is none there. But then when we get to
11 exchange coverage, we see the ranges by states of the share
12 of children who would face cost sharing and premiums at 2
13 percent of income, at 5 percent of income, and 10 percent
14 of income. And it is this bottom bank that we are turning
15 to for the third part of the analysis that I'm presenting
16 here today, and that is, okay, well, among these children
17 who are going above these thresholds, what are their
18 characteristics?
19 So the key findings from the new analysis are
20 that children crossing the various spending thresholds have
21 high health care use, and, of course, that's almost
22 tautological because the reason they have high cost sharing

1 is because they're using health care. But some of the
2 specific findings are interesting. Over half of children
3 with out-of-pocket spending of more than 10 percent of
4 income had a hospitalization during the year, so this
5 illustrates the kinds of utilization that's driving that
6 spending.
7 Secondly, children with treatment for chronic
8 conditions make up a majority of those who would have high
9 out-of-pocket spending in exchange coverage. On the other
10 hand, though, there is also a sizable group of otherwise
11 healthy children who experienced an unexpected acute
12 episode that causes high health care spending, children who
13 do not have a chronic condition.
14 So the next two tables provide the details of the
15 third piece of our analysis, and this will be going into
16 the chapter as the final piece of this.
17 So what this shows is we're looking here at the
18 share of children with out-of-pocket spending that exceeds
19 2 percent of family income and 5 percent of family income
20 and 10 percent of family income. So when we look at
21 hospitalizations, for example, 5 percent of the children
22 who would have more than 2 percent of their family income

1 going to cost sharing and premiums in exchange coverage, 5
2 percent of them had a hospitalization. To cross that 5
3 percent bar, 27 percent of those kids had a
4 hospitalization. And then 56 percent of the kids crossing
5 that 10 percent of family income bar had a hospitalization.
6 And you see how the rest of the numbers flow out with
7 increased emergency department usage, higher usage of
8 prescription drugs, and also worse health for those who
9 have the highest out-of-pocket spending.
10 And then the final table then looks at, well,
11 what are the conditions that these children have who are
12 crossing these thresholds in terms of out-of-pocket
13 spending, and you see for that first row of numbers,
14 treatment for a chronic condition, that among those who are
15 crossing the 5 percent and 10 percent thresholds, a
16 majority of them had a chronic condition. But, again, the
17 next row down, more than a third also consist of kids who
18 do not have a chronic condition but have treatment for
19 acute care conditions.
20 In our last meeting, we had talked about how
21 there were three conditions that made up the highest
22 spending for children, and those were mental health

1 conditions, asthma, and trauma. And so we wanted to bring
2 those to you in particular and show you how the trends work
3 on those as we go higher up the scale for spending
4 thresholds. And on these you see, again, how the children
5 who are crossing the higher spending thresholds in exchange
6 coverage have these conditions to a greater extent.
7 So that is the final part of the analysis that
8 will be going into the chapter based on the findings that
9 we received from the Actuarial Research Corporation, and
10 just before we turn it over to your discussion questions
11 and further discussion and then we will go to the next
12 presentation, how do the varying characteristics of
13 children with high health care spending affect the
14 Commission's consideration of options related to the
15 affordability of coverage? So they're not all kids with
16 chronic conditions, for example. It's more of a
17 complicated mix. And, secondly, what types of
18 affordability policies would be best suited to low- and
19 moderate-income children with these characteristics?
20 Thank you very much.
21 VICE CHAIR GOLD: Before we get into the
22 discussion of what the data mean, I just want to go to the

1 table on page 8. I am kind of confused. I'm looking at
2 the first two sets of rows of numbers. It's page 8, the
3 chart on health care conditions. So 36 percent have --
4 EXECUTIVE DIRECTOR SCHWARTZ: Chris, can you flip
5 the slide back to number 8?
6 MR. PETERSON: Okay.
7 VICE CHAIR GOLD: I'm looking at two different
8 things. Okay. So if 100 percent would explain all the
9 kids who went over these income limits, 36 percent had a
10 chronic condition. One hundred minus 36 percent times 0.37
11 would be the other share. If someone didn't have a chronic
12 condition or an acute condition, how did they manage to go
13 over the income limit? Or am I miss -- I'm asking this
14 because I think I'm misunderstanding, and I think --
15 MR. PETERSON: There are other services that are
16 being used that are not associated with being a chronic or
17 an acute condition. That includes a bunch of other
18 services that were dental, preventive -- and I forget the
19 list -- ambulance --
20 VICE CHAIR GOLD: But you could go over -- you
21 could not have a diagnosis that's chronic and not have a
22 diagnosis that's acute, and maybe 40 percent of -- that

1 could be 40 percent of people that could still go over the
2 out-of-pocket limit?
3 MR. PETERSON: But that's for the 2 percent
4 group, so that's a low bar. I mean, really you --
5 VICE CHAIR GOLD: But even the other one isn't
6 that high. I mean, I guess -- I'm just trying to explain
7 it, and I think it would be useful whenever you redo this
8 chart to be able to --
9 EXECUTIVE DIRECTOR SCHWARTZ: These aren't
10 mutually exclusive groups.
11 VICE CHAIR GOLD: Well, I'd like to see it, if I
12 can, with the way to -- the first two. I'm not looking at
13 the last three lines. I'm looking only at the first two
14 rows. Those are mutually exclusive, but they have
15 different denominators, and I don't know how I get them to
16 add up to 100 when you add a third row in and what that
17 third row is.
18 MR. PETERSON: Right. So the third row --
19 VICE CHAIR GOLD: And that's what I'm raising
20 that's confusing to me, because I would have thought that
21 if you're going to go over the limit, chances are you had a
22 chronic condition, or if you didn't, something happened to

1 you acutely. But obviously that isn't the case if the data
2 is good, because there are all these other people that
3 don't fall in, and I can't figure out what share those
4 other people are, because I don't know 100 minus 36 equals
5 times 0.37, or whatever, you know, the math is. It
6 confuses me. And so I think getting the numbers straight
7 and also being able to explain how you could fall outside
8 those groups and still have a large share of expenses would
9 be valuable in understanding what these data say.
10 MR. PETERSON: Yes. The third row that one could
11 put in is treatment not related to a chronic or an acute
12 condition, and we can define that. I think to your point,
13 where you're wanting to take 100 minus the other things,
14 for the 5 percent and the 10 percent that's where you get a
15 very, very small leftover amount.
16 What you've pointed to is the 2 percent of family
17 income, and my point is that that's a fairly low bar for
18 children to cross. And so just by virtue of the premiums
19 that they would be paying in exchange coverage with very
20 minor cost sharing, that is still going to put a lot of
21 kids over that threshold.
22 VICE CHAIR GOLD: So I think some of this may be

1 a labeling issue on the second row. It isn't among those
2 not treated by a condition. It's those treated for an
3 acute condition but have no diagnosis of a chronic
4 condition. So it is mutually exclusive from the top bar.
5 Right? Or not?
6 MR. PETERSON: The second row is excluding those
7 who are in the first row.
8 VICE CHAIR GOLD: So there's a labeling issue as
9 well, and it wouldn't look as --
10 CHAIR ROWLAND: I think what she wants to say is
11 that the first bar is treatment -- individuals who are
12 being treated and have a chronic condition, so those are
13 individuals with a chronic condition. The second row is
14 individuals who are treated for an acute condition but do
15 not have a chronic condition.
16 VICE CHAIR GOLD: Yes.
17 CHAIR ROWLAND: And what Chris is saying is that
18 then there are other people who are not treated for either
19 an acute condition or a chronic condition who have premiums
20 and cost sharing and other issues that put them over the
21 top in the 2 percent. But that group gets very, very small
22 when you get into the 5 and 10 percent.

1 VICE CHAIR GOLD: Yes, and if I can add together
2 the 36 and the 37, I know what you're saying, but the label
3 doesn't suggest that I can do that. But you can fix that
4 easily.
5 EXECUTIVE DIRECTOR SCHWARTZ: But, Marsha, you
6 could also have people in the box that are not there. You
7 could imagine a scenario where it doesn't add up because
8 their total out-of-pocket spending does not exceed 2
9 percent of income. So they could have some very modest use
10 and don't exceed 2 percent of income. So trying to add
11 these things up --
12 VICE CHAIR GOLD: Well, I thought the denominator
13 on those files is whatever kids fall in that out-of-pocket
14 threshold, and you're just looking at that group, what
15 share have a chronic condition or what share don't have a
16 chronic condition but have an acute condition.
17 CHAIR ROWLAND: The denominator on the column is
18 children with out-of-pocket spending exceeding 2 percent--
19 EXECUTIVE DIRECTOR SCHWARTZ: I guess what I am
20 trying to say is that the population of interest is the
21 whole population, not just those with out-of-pocket
22 spending that exceeds 2 percent of income.

1 CHAIR ROWLAND: Right.
2 EXECUTIVE DIRECTOR SCHWARTZ: There's a group of
3 kids that you're interested in that might have very, very
4 modest -- in thinking for the future about the design of a
5 policy, you're thinking about the entire range of kids.
6 CHAIR ROWLAND: But here we were just answering
7 the question of if you have high out-of-pocket
8 expenditures, what are you likely to be having those
9 expenditures for?
10 Sheldon, did you have a question?
11 COMMISSIONER RETCHIN: Maybe others are
12 experiencing -- when I first looked at it --
13 CHAIR ROWLAND: It made sense.
14 COMMISSIONER RETCHIN: What? What's that?
15 CHAIR ROWLAND: Did it make sense when you first
16 looked at it?
17 COMMISSIONER RETCHIN: It definitely did not.
18 CHAIR ROWLAND: Okay.
19 COMMISSIONER RETCHIN: No. I was having problems
20 with whether the percentages were reflective of a
21 predictive value, which would go horizontally, or was it a
22 sensitivity, which is the way it is displayed? That is, of

1 those with 10 percent of family income out-of-pocket
2 spending, 53 percent had one or more hospitalizations among
3 these children; whereas, from a policy standpoint, I might
4 be interested in more of a predictive model, that is, those
5 with mental health condition, treatment for asthma, poor
6 health, building a model so I would know where the
7 likelihood is that they would actually get to the 2, the 5,
8 and the 10. Do you see -- it's sort of almost like an
9 ordinal regression. But maybe I'm wrong. Maybe I'm seeing
10 it wrong. But it looks to me like from a policy
11 perspective, I want to know how the characteristics predict
12 the out-of-pocket --
13 CHAIR ROWLAND: This is the frequency, but not
14 the predictive characteristics.
15 COMMISSIONER RETCHIN: That's correct. It's more
16 like a sensitivity from a policy perspective. Like you
17 said, it's somewhat tautologic, especially on the upper
18 half.
19 MR. PETERSON: But the reason we did this was in
20 response to your questions about crafting a policy,
21 thinking about the future of children's coverage where, if
22 there are children who face the highest out-of-pocket

1 spending, are there things that can be done to target those
2 children and protect them? And so, for example, it would
3 have been, well, are kids who are crossing the 5 percent
4 threshold, do they all have chronic conditions? Do they
5 all have conditions that we can flag in advance and say,
6 hey, we can move you over to some other kind of coverage
7 that right now doesn't provide the cost-sharing protections
8 that we want. But we can flag you as a chronic care -- a
9 kid with chronic conditions and then help you out.
10 So these results show you, well, that only
11 accounts for 59 percent of the kids who are crossing the 5
12 percent threshold. Only 59 percent of the kids who would
13 have spending of more than 5 percent of income have a
14 chronic condition. So that's not going to be a policy
15 solution by itself. So that was the genesis of this
16 analysis.
17 CHAIR ROWLAND: You know, I think that one of the
18 other problems is that, you know, I see things usually as
19 bars instead of in tables, and that what you really would
20 be showing are the first two lines in a bar graph, so you
21 could see kind of what's going on. And it's confusing
22 because then you break down, and you have subsets

1 underneath. So I think some of this is not the analysis,
2 but it's the display, and we can work on that.
3 COMMISSIONER GABOW: I think it's always useful,
4 for me at least, to know if you are in one of these bins
5 that you go over 5 percent, what is that number as a mean?
6 Does that mean it's $1,000, $2,500? And then how does that
7 relate to the discretionary income that's available for
8 people at that level of income? Because if half of the
9 kids with a chronic condition go over 10 percent and that
10 exceeds their total discretionary income for the year, then
11 that is a very bad thing.
12 And so being able to -- I don't think people work
13 very well in thinking about these in percentages and what
14 that means actually to a family being able to live. So if
15 we could connect it to what the dollar amount would be and
16 then how that relates to their known discretionary income,
17 it would help make it more realistic or unrealistic to even
18 think about this. If it's going to put every one of those
19 families into bankruptcy or drive them out of their home
20 because they won't pay rent, then we have a bigger problem
21 than they're exceeding the 10 percent.
22 MR. PETERSON: So as we are crafting the chapter,

1 Patty, I have you in mind.

2 COMMISSIONER GABOW: Thank you.

3 MR. PETERSON: I know you want this.

4 COMMISSIONER GABOW: Even though I'm not here,

5 you'll still be seeing me in your dreams?

6 MR. PETERSON: It is in there. It was in the --

7 first of all, this was information that we presented in

8 October and September, and it was in the last paper. I

9 didn't want to put that table up again, but in terms of

10 crossing those thresholds, for a family of four let's say

11 at 225 percent of poverty, 2 percent of income would be

12 $1,091; 5 percent of income would be $2,728; and 10 percent

13 of income would be $5,456. And annual income at that level

14 is $54,563. So that's point one. We have that

15 information. We presented that last time.

16 COMMISSIONER GABOW: Sorry if I forgot that you

17 brilliantly already gave me the data.

18 [Laughter.]

19 COMMISSIONER ROSENBAUM: So my question goes to

20 what do we know about the kind of out-of-pocket spending

21 that's going on. So there could be several different kinds

22 of out-of-pocket spending, and I think that may relate

1 significantly to how we -- what recommendations we make.
2 The out-of-pocket spending could be high cost sharing for
3 covered services. It could be high cost sharing because of
4 a lot of exclusions and, therefore, a lot of uncovered
5 services. For example, I'm trying to think of an example.
6 Most CHIP plans cover hearing aids. So last night,
7 ironically, I get an email from a mother in Vermont, of all
8 places -- I was a little surprised just because I don't
9 have -- a former Vermont resident, I think, you know,
10 Vermont is sort of perfect. But it turns out that she's in
11 an exchange plan with a child who doesn't -- and the plan
12 doesn't cover hearing aids. So I think that what we have
13 to say about high out-of-pocket not only has to do with the
14 financial burden on the family and how we read these
15 charts, but are they experiencing high out-of-pocket
16 because what's inside the plan design is simply not covered
17 sufficiently? Or is it because the plan design has a lot
18 of exclusions? And there, I think that the experience of
19 acute children and chronic children will really make a big
20 difference.
21 For an acute child, what we're looking at is
22 probably children who are, you know, in a terrible

1 accident. I mean, they're hit by a car or something, or
2 they become acutely ill, they're in the hospital emergency
3 department and getting medical treatment and maybe surgery
4 or whatever, and then recovery.
5 For children with chronic conditions, whether
6 they're physical or mental, there's going to be a lot of
7 habilitation services, a lot of therapy services
8 potentially, a lot of -- a mix of services that may either
9 be totally excluded or may fall outside the upper treatment
10 limits of the plan design. You may have four therapy
11 visits a year and that's it.
12 So I would say that in terms of constructing a
13 remedy for high cost sharing problems, we not only need to
14 know something about the conditions of the children, but we
15 need to go beyond just the dollar question and beyond what
16 CMS has been able to tell us in its upper-level conclusion
17 and look back at the drilldowns on the actual design
18 differences and see what we can figure out.
19 MR. PETERSON: So two points. One is that this
20 analysis was only looking among the core benefits, so
21 COMMISSIONER ROSENBAUM: So they're all covered.
22 These are all [off microphone] --

1 MR. PETERSON: Right.

2 COMMISSIONER ROSENBAUM: But it could be a
3 limitation on a core benefit. It could be four therapy
4 visits a year, and then you're in excluded coverage land.

5 MR. PETERSON: Yes. I'm not confident that the
6 ARC model took all of those things into account, so that's
7 number one.

8 And, number two, we had asked about the extent to
9 which they could tell us was it -- I mean, we see these
10 high rates on the hospitalization, but we wanted to know
11 how much of the dollars was from hospitalization on out-of-
12 pocket versus, let's say, prescription drugs. And they
13 said they couldn't do that, and the reason is you could
14 have a child who has a certain amount of drug spending
15 during the year and a certain amount of hospital spending
16 during the year, and they might hit the out-of-pocket
17 maximum if they have all that drug spending first and then
18 the hospitalization is free, or vice versa, if the
19 hospitalization came -- and so they said we don't feel
20 comfortable trying to give you that level of specificity.

21 COMMISSIONER ROSENBAUM: I do think that means
22 that what we're going to have to do is borrowing from our

1 own research and other research sources, note in our
2 writing about this that there could be a number of
3 different drivers, and that the data simply are not refined
4 enough to tell us precisely what's driving this, but that
5 there's evidence to support any number of drivers, and
6 whatever remedy we come up with is going to have to be a
7 remedy that can respond to these drivers. I mean, it's the
8 same issues that, to a lesser extent, bedevil CHIP. There
9 are, you know, states that exclude things from CHIP
10 entirely. The only program we have where in theory -- and,
11 you know, it's not accurate to say this, but in theory, you
12 don't have this exclusionary design problem in Medicaid,
13 and even there, I mean, you hit exclusions.
14 And so I think that this will be a case where we
15 get the best evidence we've got, and then we're just going
16 to have to explain what we can't tell from our own work but
17 what we may be able to draw on from other sources.
18 CHAIR ROWLAND: I guess I would also enter the
19 caution that this is a model.
20 COMMISSIONER ROSENBAUM: Right.
21 CHAIR ROWLAND: It's not like actually count --
22 so it's got a lot of assumptions built into it, which I'm

1 sure our next speaker, who is an actuary, will tell us all
2 about.
3 COMMISSIONER HOYT: Maybe later.
4 [Laughter.]
5 COMMISSIONER HOYT: I'm not sure if this was
6 embedded in your answer to an earlier question, but I
7 thought it might be helpful in the headings or the labeling
8 to the tables if you could -- assuming you know this, and
9 I'm guessing you do, what percentage of all the kids are in
10 the far-right column? So it's like 7 percent of kids had
11 expenses that exceeded 10 percent of income, 21 percent of
12 the exchange kids, you know, were in this column where it
13 exceeded 5 percent.
14 MR. PETERSON: It's in the bottom right-hand
15 corner right there. So it's not a lot of kids. So we're
16 looking at the second lowest-cost silver plans, and the far
17 right-hand column shows you 10 percent of income. So we're
18 talking about, you know, states ranging -- they have 1
19 percent of kids, 2 percent, 3 percent of kids who are
20 crossing that 10 percent of income threshold. So there
21 aren't a lot of kids on which that part of the analysis is
22 based.

1 COMMISSIONER HOYT: I guess it would be helpful
2 to me if you could collapse that down into the overall
3 group average or something and also put it in the secondary
4 set of tables, because it sounded like somebody had the
5 impression that half of all the kids have a chronic
6 condition. It's, like, no, that's not right. There's only
7 3 percent of the kids that are in this category, 58 percent
8 of them do have a chronic condition.
9 MR. PETERSON: Right.
10 COMMISSIONER HOYT: So I'm going back to -- so
11 maybe to link the two together.
12 COMMISSIONER SZILAGYI: Actually, I was going to
13 make that exact point. It wouldn't help in terms of the
14 variability across states, but it could help in terms of
15 for the entire United States. You know, you can just make
16 one row, I think, for the bottom part of this graph, and it
17 probably would come out to somewhere around 150 to less
18 than 200 percent, for the most part, because that's the
19 CHIP population.
20 I was going to make several other points. I
21 think, Chris, what you said probably is worth emphasizing,
22 that these data suggest that we can't predict the kids who

1 are going to have more than 5 percent of family income
2 paid, because -- for several reasons. Because a large
3 percentage, a reasonable percentage have an acute
4 condition, probably a trauma, and so they ended up in the
5 emergency department, or then were hospitalized, and then
6 had a problem. And then they exceeded 5 percent or
7 exceeded 10 percent. And because there is evidence that
8 chronic disease in children is not as stable as people
9 think, so kids will develop a chronic disease. So it would
10 be hard to predict and be able to sort of carve out some
11 population so that we would protect families from ever, you
12 know, exceeding 5 percent.
13 Another point I was going to make is that these
14 services, hospitalizations and ED visits, are not elastic.
15 So unlike preventive services, one could argue that if it's
16 preventive services that kick families over 5 percent or 10
17 percent, maybe parents would forgo those. But they're not
18 going to forgo hospitalizations or trauma-related ED
19 visits. So even though these are models and they're not
20 perfectly predictive, it's like that this will happen
21 because these services are not as elastic based on other
22 evidence.

1 And then the last point I was going to make is
2 that there may be an effect on disparities here, because we
3 and others have shown that even within the CHIP population,
4 black and Hispanic patients are more likely to have a
5 mental health problem and asthma. And so to the extent
6 that we'll be following your data, not on this slide but on
7 the next slide, this may exacerbate disparities within the
8 CHIP population.
9 COMMISSIONER RETCHIN: I don't know, Peter, when
10 you said you can't predict from these data. Again, I think
11 it's the way -- if you ask the question of children with
12 these characteristics, how many exceed 2 percent, 5
13 percent, and 10 percent. The way this was asked was of
14 those who've exceeded, how many have these characteristics,
15 and that's why the low numbers, I think, because here is
16 what you would conclude in the end. Let's say, because the
17 numbers are incredibly small in the right-hand column. I
18 would imagine that they're -- if you have an intervention
19 based on this, say we're going to go after kids with poor
20 health, well, you would spend a huge amount of money trying
21 to avoid the out-of-pocket costs for a very small number of
22 people. It's like statins. You'd be using -- you'd be

1 treating or intervening on a lot of kids who are never
2 going to reach that threshold. That's why I think a
3 multivariate analysis of this going -- using
4 characteristics to predict outcomes. At least that's the
5 way I would look at it.
6 VICE CHAIR GOLD: Yeah, I actually want to go
7 back, go to your question then, discussion questions. I
8 guess one of the things -- it seems like you might have the
9 implication that we could make a recommendation that kids
10 with a certain health condition -- that would be your
11 thing, Sheldon -- or kids who exceed the threshold who also
12 have these circumstances would be treated differently than
13 other kids.
14 A whole alternative approach is to, you know,
15 just say the kids will have a lower out-of-pocket threshold
16 than currently exists in the exchange plans. Or, you know,
17 you could also say what Sara's question was getting to, if
18 you could figure out that there were certain benefit and
19 cost-sharing structures that got you here more, you might
20 modify the benefit and cost-sharing structures for
21 children. And either changing the out-of-pocket limit or
22 varying the benefit and cost-sharing structures seem to me

1 a more direct approach to people's out-of-pocket expense
2 than trying to say one kid who's expensive is better than
3 another kid who's expensive.
4 CHAIR ROWLAND: Well, I think that this analysis
5 was done because there was a thought that could we identify
6 some characteristics of kids that we would protect in a
7 different way than other kids because they are likely to be
8 high out-of-pocket spenders. And I think what we see is
9 that, yes, there are some things that predict, but they're
10 also not that predictable, like a hospitalization. And
11 there are other -- and chronic conditions, certain chronic
12 conditions probably trigger you to be much more likely to
13 have a lot of out-of-pocket spending. But basically we've
14 answered the question that if we're designing a policy
15 option, it's probably not useful to design it on diagnosis.
16 It's probably more useful to look at other things.
17 COMMISSIONER GABOW: If it's true when you look
18 at the 1 percent of kids overall we're talking about and
19 then half of them have one of these that go over, does that
20 mean to our actuary that it's better to design global
21 benefit and out-of-pocket to cover them or to create a
22 catastrophic wrap-around for the people, the small number,

1 you know, one 1 to 3 percent --

2 COMMISSIONER SZILAGYI: Something like 5 percent.

3 COMMISSIONER GABOW: -- that are going to be

4 needing that from a pricing, a plan, which of those options

5 are better? It seems to me if you're dealing with a very

6 small percentage number -- but I'm not an actuary -- that

7 intuitively it would be better to have some sort of

8 catastrophic wrap than redesign a benefit --

9 CHAIR ROWLAND: It would be so simple to

10 administer.

11 COMMISSIONER GABOW: Pardon me?

12 [Laughter.]

13 CHAIR ROWLAND: That would be so simple to

14 administer.

15 COMMISSIONER GABOW: Well, the simple solution we

16 know is something very different than we're willing to do.

17 CHAIR ROWLAND: But I'll let Mark answer if he

18 wants to.

19 COMMISSIONER HOYT: I think first you just have

20 to decide what your goal is. What is it you want to

21 achieve or how do you want to steer, direct the families or

22 the kids? And then after that, it's just a math problem to

1 figure it out. Unless I just didn't quite follow what you
2 were asking me.
3 COMMISSIONER GABOW: Well, that's because I don't
4 know what I'm asking.
5 [Laughter.]
6 COMMISSIONER GABOW: But I'm asking a question
7 that if you are designing a health plan for the country for
8 children, and you know that about 2 percent of the children
9 in the current structured plan are going to exceed the 10
10 percent threshold that we don't want them to go over, or
11 the 5 percent -- pick a number -- does it make more sense
12 to design a plan for everyone so that you would catch any
13 of those who would -- any of those 5 percent who would
14 exceed? Or does it make more sense to only have a sort of
15 catastrophic safety net for that small percent so that
16 you're not designing a plan for 95 percent of people who
17 never use it, but you're creating a safety net for the 5
18 percent who have a need? Since we can't predict, since we
19 can't say we know exactly which kid is going to get hit by
20 a car, I mean --
21 COMMISSIONER HOYT: If you want to be as sure as
22 you can that you've captured as many of the kids as

1 possible, then you want a low bar at entry. You would
2 lower the premiums, make it more attractive there so they
3 can afford to buy the policy or get on the exchange, and
4 then you'd protect them afterwards if something bad
5 happened.

6 CHAIR ROWLAND: Okay.

7 COMMISSIONER RILEY: It's fascinating stuff, but
8 it strikes me that we're sort of back to where we started
9 this conversation when we decided to recommend a two-year
10 extension. The question is: Do we want to continue the
11 CHIP program, or are there reasonable alternatives? And
12 now we have a real focus, and it tells us affordability is
13 the issue, regardless really of the conditions of the
14 children.

15 So it strikes me that the kinds of policy options
16 we have are continue CHIP, and that raises the question of
17 would you do so with an enhanced match, and if there's no
18 continued enhanced match, what would the states do? Would
19 you deal with the family glitch? You know, there are
20 things within the act that one could address to solve the
21 problem. The family glitch, we're back to that discussion.

22 You could look at the essential health benefit,

1 but then you'd have to change the antidiscrimination
2 language that's in the ACA, which says that you can't
3 create benefit differentiation on age. So how do you
4 create a child-only benefit or how do you create a
5 children-friendly benefit within that structure? And can
6 you? Could you convert CHIP dollars to APTCs? Could you
7 require that the Medicaid program must serve all frail
8 children up to age -- up to 200 percent? I mean, it seems
9 to me these are the policy options for the Congress that we
10 need to play out now that we have this --
11 CHAIR ROWLAND: It's actually interesting to me
12 that my Commission members so ably transition us to the
13 next part of our discussion.
14 EXECUTIVE DIRECTOR SCHWARTZ: Too bad you're not
15 going to be here in January.
16 COMMISSIONER RILEY: I know. That's why I'm
17 trying to get it all in now.
18 [Laughter.]
19 EXECUTIVE DIRECTOR SCHWARTZ: So the question
20 was: Do you have the answer, now that you've framed it --
21 [Laughter.]
22 COMMISSIONER SZILAGYI: Could you just clarify

1 what you said about the ACA, that there's no age --
2 COMMISSIONER RILEY: Individual and small-group
3 products on the exchange, there's an anti -- for all the
4 right reasons, there's an antidiscrimination provision that
5 says you can't discriminate by age, sex, physical
6 condition. But that really then creates a question about
7 whether you can really create a program, a policy that
8 would be for children only. That is the extent of my
9 knowledge of insurance regulation, but --
10 COMMISSIONER ROSENBAUM: There is a pediatric
11 benefit class which in theory would allow you to broaden --
12 I mean, I think we're right, we have pushed the discussion
13 into the next phase --
14 CHAIR ROWLAND: Except Sharon had her hand up, so
15 I'm honoring Sharon, who is a CHIP Director.
16 COMMISSIONER CARTE: Thank you. Well, in
17 correlation to some of those things, I just thought that
18 the issue of co-payments should be looked at or juxtaposed
19 to the fact that for low- and medium-income families it's
20 still quite a sacrifice just to be paying the premium, and
21 we might want to look at how many families drop out from
22 paying the premium, and also since that relates to the

1 viability of the exchanges and that these kinds of co-
2 payment and medical issues simply teach families that
3 they're not getting any protection when they're making a
4 great sacrifice to have some for their children.
5 CHAIR ROWLAND: So let's move on, Chris, to the
6 policy issues.
7 MR. PETERSON: The policy issues regarding --
8 CHAIR ROWLAND: -- in the Medicaid-Expansion CHIP
9 program.
10 **### Analysis and Updates on Children's Coverage:**
11 **Policy Issues in Children's Coverage: Medicaid-Expansion**
12 **CHIP Programs**
13 * MR. PETERSON: All right. So this is my second
14 presentation.
15 As you know, states can run their CHIP program
16 simply as an expansion of Medicaid, which nine states do,
17 or as a program entirely separate from Medicaid, which now
18 only two states do, or they can have both a Medicaid-
19 expansion and separate CHIP programs, and such combination
20 programs now exist in 40 states.
21 Most of our prior work has focused on separate
22 CHIP rather than Medicaid-expansion CHIP programs because

1 of the near-term possibility of federal CHIP funding
2 ending. Without CHIP funding, children in separate CHIP
3 would lose their coverage, but states must continue
4 Medicaid-expansion CHIP coverage through at least fiscal
5 year 2019, because of the maintenance of effort for
6 children that was enacted in the ACA. So this meant that
7 children in Medicaid-expansion CHIP were not at risk of
8 becoming uninsured when CHIP funding ran out, but states
9 would have to pay a lot more for those children's coverage.
10 So these were some of the issues that we want to review
11 today regarding the future of Medicaid-expansion CHIP
12 coverage.
13 So today I just want to provide some context to
14 this discussion and then talk about the future
15 implications, particularly on Medicaid-expansion CHIP
16 program, of two things: CHIP funding running out in 2018
17 and the maintenance of effort expiring in 2020.
18 As a reminder, children who are enrolled in
19 Medicaid-expansion CHIP are enrolled in Medicaid. They are
20 entitled to Medicaid services. They are, as far as they
21 know, Medicaid children, but they are financed by CHIP at
22 the CHIP matching rate. And the income level for Medicaid-

1 expansion CHIP is based on state's Medicaid eligibility
2 levels in 1997. So, for example, in your materials, in Tab
3 5B was the table that shows the eligibility levels by state
4 and where Medicaid funding leaves off and where CHIP
5 funding begins, and it varies all across the states because
6 it's based where states were in their Medicaid coverage of
7 children in 1997.
8 If CHIP funding is exhausted, then coverage
9 becomes financed by Medicaid at the Medicaid managing rate
10 for Medicaid-expansion CHIP programs. That's a key
11 distinction, so for Medicaid-expansion CHIP programs they
12 have the ability to fall back to Medicaid funding if the
13 money runs out, whereas in separate CHIP, once the CHIP
14 money runs out, then that's it.
15 And I just want to show you the range of the
16 federal matching rate for states. Prior to 2016, kind of
17 the historical ranges -- the federal CHIP matching rate was
18 65 to 82 percent, whereas Medicaid was 50 to 74 percent for
19 benefits. Right now we are in this 4-year period where
20 that 23 percentage point increase in the CHIP matching rate
21 is in effect, so now it's ranging from 88 to 100 percent,
22 while Medicaid has not changed for most services. And

1 after 2019, if there's still CHIP funding, then the
2 matching rate under current law falls back to its typical
3 levels for CHIP, 65 to 82 percent.
4 For CHIP buffs, you are interested to note that
5 now most enrollees in CHIP are now in Medicaid-expansion
6 CHIP. The ACA required the transition of what we call the
7 stairstep children, those who were 6 to 18 years old and
8 who were previously covered in separate CHIP, between 100
9 and 133 percent of poverty. The ACA required them to be
10 moved over to Medicaid coverage, and since they were
11 already funded by CHIP then they just become the Medicaid-
12 expansion CHIP coverage. And some states have voluntarily
13 converted from separate CHIP to Medicaid-expansion CHIP,
14 most notably California.
15 COMMISSIONER ROSENBAUM: Do we know whether --
16 and maybe Sharon would know -- on the stairstep children
17 it's obvious, but the other children, is that because of
18 states' concern that the CHIP money would end, and that at
19 least if they were in Medicaid, the normal federal
20 contribution rate would be available? Do we know anything
21 about why states made that choice?
22 MR. PETERSON: So we've heard a number of

1 reasons. One is what you've mentioned, the ability to fall
2 back to Medicaid funding if CHIP money were to end, and
3 there are a lot of other reasons -- the ability to access
4 the Medicaid rebates, the -- I'm trying to think of some of
5 the other reasons. But a lot of them were related to cost,
6 and there's also simplification, administrative
7 simplification, right? What we've talked about is do we
8 need this stand-alone program existing, and states have
9 asked themselves that at the state level. Is there a
10 benefit? And that's kind of the tradeoff that they've
11 tried to wrestle with.
12 And in this figure, then, you see, historically,
13 that separate CHIP coverage has been about 70 percent of
14 enrollment, but the latest numbers that we have now show
15 that Medicaid-expansion CHIP coverage now makes up the
16 majority at 58 percent.
17 VICE CHAIR GOLD: How much of that is California?
18 MR. PETERSON: A good chunk of it. A good chunk
19 of it.
20 VICE CHAIR GOLD: That's what I thought, because
21 an awful lot of states didn't have separate CHIP programs,
22 right? It might be worth sort of somehow figuring out how

1 to show that.

2 CHAIR ROWLAND: Most states had separate CHIP

3 programs.

4 COMMISSIONER ROGERS: Most states had separate

5 CHIP programs?

6 CHAIR ROWLAND: Yeah. But the other interesting

7 thing to look at the 2015 distribution here is what the

8 income levels are of Medicaid-expansion CHIP kids, what

9 that income distribution is versus the separate CHIP kids.

10 MR. PETERSON: Right. So if we can separate out

11 who the stairstep children are, then it might be possible

12 to differentiate that, but as, you know, the recent history

13 indicates that the SEDS data, they're still working on

14 trying to make sure all this is good. So not sure we'll be

15 able to do that, but that's our desire.

16 CHAIR ROWLAND: Because of the stairstep, all of

17 the kids under 133 are now in the Medicaid-expansion CHIP?

18 MR. PETERSON: Yes.

19 CHAIR ROWLAND: So the poorest children, which is

20 why all your other charts started at 133, are already in

21 Medicaid?

22 MR. PETERSON: And this is just a timeline of

1 some of the key policies, and I just want to talk about the
2 two on the far right, that we're going to turn to next, and
3 that is during fiscal year 2018, states will be exhausting
4 their CHIP funding under current law, and then the
5 maintenance of effort expires at FY 2020, and the 23-point
6 increase in the CHIP matching rate also ends.
7 So to talk about the implications of those two
8 things, let's start with the implications of CHIP funding
9 ending in fiscal year 2018. Medicaid-expansion CHIP
10 programs may not reduce their eligibility levels because of
11 the maintenance of effort that is in effect, but Medicaid-
12 expansion CHIP programs would be receiving the Medicaid
13 matching rate at that point, rather than the CHIP matching
14 rate, once that money runs out, and that means that 49
15 states, including the District of Columbia, would be
16 affected by this. They have Medicaid-expansion CHIP
17 enrollees, and then would be affected by the reduced
18 federal share.
19 And then as we turn to the maintenance of effort
20 ending in 2020, states may then roll back Medicaid
21 coverage, including Medicaid-expansion CHIP coverage, down
22 to 133 percent of poverty. We have new estimates from the

1 Urban Institute that if all states rolled back to the
2 maximum extent possible, 2.3 million children would be
3 projected to lose Medicaid-expansion CHIP, and of those,
4 700,000 would become uninsured, and this is on top of the
5 1.5 million who would become uninsured without separate
6 CHIP in 2020. But it's also important to note that, again,
7 133 percent of poverty is now the new eligibility minimum
8 for children of all ages, and so those children who are
9 currently funded by CHIP, who are below 133 percent of
10 poverty, states must continue to cover them in perpetuity,
11 with or without CHIP funding.
12 So I will conclude with some discussion
13 questions. One, do the circumstances facing children
14 covered by Medicaid-expansion CHIP affect your
15 consideration of options for the future? What are the
16 implications for state budgets of reverting to the Medicaid
17 matching rate in 2018, and given that, how likely, in fact,
18 are states to roll back Medicaid eligibility to 133 percent
19 of poverty in 2020? And what would be the implications of
20 moving to more uniform standards nationally, not only for
21 children's income eligibility but also where the line is
22 for enhanced federal matching.

1 Thank you.

2 CHAIR ROWLAND: I think we have spent a lot of
3 time focusing on this effort, CHIP program, so I think it
4 is important to keep our discussion cognizant of the fact
5 that there is a lot of movement on the Medicaid side of
6 this. I also think that the table that Chris alluded to,
7 showing you where the Medicaid income eligibility levels
8 are is important and that we know that the higher up the
9 income scale you go, the less likely someone is to be on
10 either CHIP or Medicaid.

11 But this is a piece of the analysis that I think
12 is very important as we look at if CHIP were to end, what
13 would happen to these children, and it's both a matching
14 rate and a state policy decision of whether they continue
15 them. But the good news is that children have generally
16 been positively reviewed and covered by the states.
17 They're not the most expensive beneficiaries in the states.
18 But we also know that, you know, budgets can be tight.

19 What are you thinking, Chuck? You look like
20 you're very pensive.

21 COMMISSIONER MILLIGAN: Well, I'm thinking about
22 the fact that the maintenance of effort ended for adults

1 and to what extent have we seen evidence of retracting that
2 eligibility, because I don't think there's been a lot, but
3 I haven't looked at it deeply. It's a tricky issue. But I
4 was thinking about, you know, there is a little bit of
5 evidence on the adult side about MOE.

6 CHAIR ROWLAND: Sara.

7 COMMISSIONER ROSENBAUM: I think -- I mean, here,
8 again, just to sort of separate the issues out, there is
9 this one group of children, the so-called stairstep
10 children, who remain in Medicaid, regardless of the loss of
11 enhanced CHIP spending, because the change in eligibility
12 standards for them was a permanent one. I mean, it was
13 just made to the underlying statute as opposed to the
14 federal enhancement rules.

15 On the other hand, it's, I think, rather clear
16 that there's, you know, definitely a -- what I would call a
17 range of views on whether those children should be in the
18 mandatory eligibility group. We see that, you know, range
19 of opinion in the pending reconciliation legislation. We
20 have seen issues around children, poor children up to the
21 age of 18 in the maintenance of effort litigation.

22 So I think one of the things we have to be

1 mindful of is that putting aside the fact that in the over-
2 138 percent world for adults there's room now to cut, and
3 the cutting is not happening. The stairstep children have
4 attached more than their share of scrutiny, I would say,
5 and I mean, that, in the end, is just one factor, but I
6 think it's an important factor for us, that there was
7 consensus, or relatively broad consensus that you'd cover
8 children from 6 to 18 at 100 percent of poverty, and
9 clearly not so much consensus about the 6-to-18-year-olds
10 in that increment.
11 CHAIR ROWLAND: Okay. Andy?
12 COMMISSIONER COHEN: No answers here, but I did
13 just want to sort of reiterate a point that we've talked a
14 little bit about before, and kind of relates to Chuck's
15 good suggestion to look what's happened with adults. We're
16 in a good period, economically, and, of course, we know
17 that Medicaid -- and any time states have discretion to
18 raise or lower eligibility standards and economic
19 conditions change, that's something that changes too.
20 So, I mean, a really important -- I'm always just
21 hesitant about us only looking at what present sort of
22 conditions and present behavior is, because one of the key

1 characteristics of Medicaid and CHIP are the programs that
2 are sort of where there's broad discretion of the states is
3 that economic conditions makes huge differences in terms of
4 what beneficiaries get, and the advantage of the federal,
5 you know, sort of exchange system is that that is not as
6 likely to be true. Obviously Congress can change its mind
7 just like a state legislature can change its mind, but
8 effectively it doesn't. History has not suggested that
9 that is as likely to happen.

10 So I just -- it's really important that we not
11 just look at current behavior to guide our thinking on
12 this.

13 CHAIR ROWLAND: Sharon.

14 COMMISSIONER CARTE: Excuse me. I know that CHIP
15 directors in states have had discussions before about the
16 lead time needed to transition CHIP programs, which means
17 that, really, I hope the Commission will take a strong look
18 at these issues in the coming year of 2016, because by the
19 fall of 2016 we will be a year away from the expiration of
20 funds, federal funds, and the more background and light we
21 can shed on this, the better.

22 CHAIR ROWLAND: Chuck.

1 COMMISSIONER MILLIGAN: Just a couple of other
2 points that I want to maybe build on. I do think it's
3 worth looking at, as I mentioned a minute ago, about what's
4 going on with adults, and in particular there are
5 eligibility categories that have gone up pretty high --
6 pregnant women is an example -- where I'm not sure what the
7 evidence is about states sort of pulling back coverage on
8 the theory that those women now have access to QHPs, but I
9 think that that would be instructive, just to kind of track
10 as an indicator, if nothing more.
11 I want to pick up on Andy's comment for a second.
12 My view is that when states are in tight budget situations
13 it's much less likely to cut eligibility than some of the
14 other tools you have at your disposal, cutting provider
15 rates, and running afoul of the access rules. I mean,
16 there's other things to do. But I think what's most
17 likely, actually, for children, would be not cutting
18 eligibility per se for the kids above 133, but I think what
19 would be more likely is either provider rate kinds of
20 things or trying to move in the direction of something
21 that's a more commercial-like benefit package, and, in
22 particular, walking back some of the EPSDT coverage rules.

1 And I do think that it implicates a lot of what
2 you presented at this meeting and other meetings about out-
3 of-pocket benefit design, are QHPs sufficient, what happens
4 to dental, what happens to therapies, what happens to a lot
5 of other things. But I think that that's the more likely
6 outcome, is walking back the benefit design and the cost-
7 sharing, and seeking a waiver, like it's still Medicaid but
8 we want it to be more commercial-like, or QHP-like.
9 So I think that the more we track some of that --
10 and I do recognize the need to address the policy question
11 of what happens when CHIP, you know, the future of CHIP
12 itself. But I think that tracking the Medicaid dimension
13 of that, that's where the action is likely to be.
14 CHAIR ROWLAND: I think it's also important in
15 that tracking to remember that as we go out in years we're
16 going to see the beginning for the states that have
17 expanded of your state contribution to the expansion, so
18 that there would be two sources of need for state
19 additional revenues.
20 Peter, did you have a comment?
21 COMMISSIONER MILLIGAN: No, I was just going to
22 ask, do we have evidence for what states did during the

1 economic downturn, in terms of the upper limit?

2 CHAIR ROWLAND: Well, they were under a

3 Maintenance of Effort so they couldn't change the

4 eligibility.

5 COMMISSIONER SZILAGYI: But -- so part of --

6 there was the MOE. Part of the tradeoff with the states --

7 I mean, not overtly -- was the federal government gave an

8 enhanced matching rate across the board for a couple of

9 years that was very significant, and that was a little bit

10 of kind of a quid pro quo for the MOE was the Medicaid

11 matching rate got a recession-related adjustment for a

12 period of time.

13 But beyond that, you know, states' first impulse

14 always is provider rates because the savings are immediate.

15 You know, you paid one amount on September 30th and a

16 different amount on October 1st, and you don't have to have

17 lag time. Other than the federal approval piece of it, you

18 don't have to wait for interventions to kind of float

19 through a system, but there's a longer tail.

20 CHAIR ROWLAND: And we're seeing now, with the

21 economy getting better, that many states have gone back to

22 the drawing boards, and so the provider rates go up and

1 down, depending on the economy, really.

2 Mark.

3 COMMISSIONER HOYT: Your second question about

4 what's the implications on state budgets for reverting back

5 to the Medicaid matching rate, don't you have the data

6 already to do that, if you just assume every state reverted

7 back? April could do that tomorrow morning, couldn't she?

8 [Laughter.]

9 COMMISSIONER HOYT: I'd be interested in hearing

10 if that would increase, you know, overall, nationwide, the

11 state share, their budgets would go up by 1 percent or 0.8

12 percent, or whatever that number is.

13 MR. PETERSON: Yeah, I think in the paper we say

14 we would take a look at that for the next round and try to

15 produce that.

16 CHAIR ROWLAND: Okay. So these are two pieces

17 that are works in progress, that will be assembled along

18 with the other pieces to really have a sort of lay of the

19 land of changes that could be coming to CHIP programs,

20 depending on what happens with the Congressional action on

21 CHIP, as well as what is going on with regard to the

22 intersection of CHIP and the exchange plans.

1 So we'll try and lay it out in a clear manner so
2 that it's easier to understand what the key takeaway points
3 are, but this is really just kind of building the evidence
4 base of what the challenges and choices are.
5 And Joanne is going to come up and give us even
6 more on the 2017 Exchange Benefit and Payment Parameters
7 Proposed Rule so that we can add that our deliberations
8 around CHIP and CHIP's future.
9 **### Analyses and Updates on Children's Coverage:**
10 **2017 Exchange Benefits and Payment Parameters Proposed Rule**
11 * MS. JEE: Okay. So this afternoon we wanted to
12 spend just a little bit of time talking about the recently
13 issued 2017 exchange benefit and payment parameters, which
14 are proposed rules. We will review the purpose of the
15 proposed rule and what it does, and then highlight some key
16 provisions that we think are most pertinent to children's
17 coverage. You may want to keep these issues in mind over
18 the course of your ongoing discussion of children's
19 coverage.
20 But before moving on to those provisions, I just
21 want to note that this is a proposed rule that is out for
22 comment. It's related to exchange and general insurance

1 market coverage, and so the Commission is not obligated to
2 comment on these rules. We're just providing this
3 information for you as an FYI just to inform your ongoing
4 thinking on kids' coverage.
5 So CMS issued these rules on November 20th, and
6 they would take effect for benefit year 2017 which would
7 start on January 1st, 2017, if they're finalized. The
8 rules govern plan participation in exchanges, and they
9 propose a number of changes and updates to rules for
10 exchange benefits and payments. But, again, today our
11 focus is really just on those key proposals that would most
12 relate to affordability and adequacy of coverage for low
13 and moderate-income children if they were to be enrolled in
14 the exchanges.
15 So the proposed rule -- in the proposed rule, CMS
16 considers a number of provisions and proposals.
17 The first is whether the age rating factor for
18 children is appropriate given the different health risks of
19 children at different ages. Commissioners, you'll recall
20 that the age rating is the factor used for determining
21 exchange premiums for children relative to premiums for
22 adults. So in the proposal, CMS doesn't propose another

1 factor per se but, rather, requests comments on what would
2 be most appropriate, including data and policy rationale
3 for any such recommendation that a commenter would offer.
4 Second, the rule also proposes to create, for
5 federally facilitated exchanges, standardized plan options.
6 Under this proposal, exchange plan issuers could choose to
7 offer standardized plans but would not be required to do
8 so, and the issuers could continue to offer non-
9 standardized plans as well.
10 So what would standardized plan options do? With
11 the standardized plan option, the issuer would use a
12 standardized cost-sharing structure, including a
13 standardized deductible level within metal tiers. A
14 standardized plan option would exempt certain services from
15 deductibles such as preventive care and generic drugs. A
16 standardized option would use four drug tiers for generic,
17 preferred brand, non-preferred brand, and specialty drugs,
18 and would use no more than one in-network tier for
19 providers so that cost-sharing wouldn't vary by provider
20 tier. And, lastly, the standardized option uses a mix of
21 co-payments and co-insurance, and within the standardized
22 option by metal tier, it's the same co-payments and same

1 co-insurance.

2 So there is one thing that the standardized plan
3 option doesn't do, and that is it doesn't change the
4 underlying affordability of the plans. It just makes them
5 look more similar to each other within the metal tier.

6 Next, the proposed rule updates annual cost-
7 sharing maximums and proposes to index the cost-sharing
8 maximum for standalone dental plans to the dental Consumer
9 Price Index. So CMS states that this approach on the
10 standalone dental plan would help the cost-sharing limit
11 increase over time to keep up with inflation and would be
12 more similar to the way the cost-sharing maximums are
13 increased for the medical QHPs, the medical exchange plans.

14 So moving on to the next set, the rule proposes
15 that states would use -- or, would assess health plan
16 network adequacy in federally facilitated exchanges, using
17 approved network adequacy metrics. If the state does not
18 conduct the review, the federally facilitated exchange
19 would, using a default standard. And in the rule, CMS
20 indicates that the default standard would likely be based
21 on time and distance.

22 CMS specifically seeks comments on a few other

1 aspects of network adequacy standards, including what a
2 standard might be for standalone dental plans, whether wait
3 times for appointments should be a standard, and whether
4 issuers should be required to survey contracted providers
5 to determine sufficiency of providers that are taking new
6 patients.
7 The rule also addresses continuity of care and
8 proposes to require that issuers notify enrollees of
9 discontinuation of providers within a certain amount of
10 time. The rule also proposes that to require that
11 federally facilitated exchange plan issuers allow enrollees
12 in active treatment to continue treatment with their
13 provider for a limited time and that in-network cost-
14 sharing would apply if the provider is terminated without
15 cause.
16 Finally, CMS proposes that when enrollees receive
17 service from a non-network provider in an in-network
18 setting, that the cost-sharing count toward the annual
19 limit or that the issuer provide written notice 10 days
20 prior to the service about additional costs that the
21 enrollee could incur.
22 The last proposal I'll mention has to do with

1 navigators, and you'll recall that navigators perform a
2 number of functions that help individuals access and
3 understand exchange coverage. They provide public
4 education and outreach. They provide information on the
5 availability of exchange plans and federal subsidies. They
6 facilitate enrollment in exchange plans, provide referrals
7 for grievances and complaints, and are to provide
8 information in a way that is linguistically and culturally
9 appropriate.

10 In the rule, CMS proposes to expand the
11 requirements on navigators so that they provide targeted
12 assistance -- they would be required to provide targeted
13 assistance to underserved and vulnerable populations to
14 improve their awareness of coverage options. And the
15 definition of underserved and vulnerable would be up to the
16 exchange -- the state-based exchanges. And navigators
17 would also be required to provide post-enrollment
18 assistance, such as helping with filing eligibility appeals
19 and helping to understand the basic concepts of using
20 health coverage.

21 So, Commissioners, those are the provisions of
22 the proposed rule that we thought had the greatest

1 relevance to your discussion on the adequacy and
2 affordability of children's coverage, and that would have
3 the greatest bearing on their coverage if they're enrolled
4 in exchanges.
5 Based on prior years' timelines, we expect that
6 the rule will be finalized in the spring of 2016.
7 If you have any questions, I'd be happy to take
8 them.
9 EXECUTIVE DIRECTOR SCHWARTZ: I just want to
10 underline something before going on to reinforce what
11 Joanne said, which is we've spent a lot of time talking
12 about the alternatives that kids would face if there is no
13 CHIP program, and the exchange is obviously a big one, and
14 we've had a lot of conversation on what it means to fix the
15 exchange.
16 The reason -- and this wasn't really originally
17 on the agenda because it's not really within the purview of
18 MACPAC, this particular rule, but to help you understand
19 sort of the dynamism of the marketplace. What those things
20 will actually be in 2018 could be quite different but to
21 sort of like file it in the back of your mind. None of
22 these are really game-changers, but it does show that some

1 of, I guess, the attentiveness of CCIIO to trying to
2 address some of the concerns that had been raised. And
3 that's really the purpose of Joanne's presentation today.
4 COMMISSIONER CARTE: I was kind of surprised. In
5 the topic of the child age rating for premium-setting, the
6 statement, "Some exchange plans have indicated that the
7 current age rating factor is inadequate, resulting in
8 children's premiums that are insufficient" seems surprising
9 given the amount of co-payment and deductibles that you see
10 in these plans.
11 And I guess -- so I just have a really basic
12 question that's kind of a technical one. Let's say that
13 CMS is prepared to adjust the age rating band for children.
14 Would they similarly be able to assure that that results in
15 a positive actuarial value?
16 I mean, I realize that the two are not
17 equivalent. We're probably talking family premiums. But
18 would there be an assurance that additional... That's my
19 question.
20 MS. JEE: I don't know all the technicalities
21 really of how the age rating occurs, and unfortunately,
22 Mark is out. But I think that's an important question and

1 certainly something that would need to be considered.

2 COMMISSIONER CARTE: Well, it could be both an

3 insurance question but also a legal question-

4 COMMISSIONER ROSENBAUM: Absolutely.

5 COMMISSIONER CARTE: -- that really would need to

6 be clarified for the Commission.

7 COMMISSIONER ROSENBAUM: Well -- and my question

8 is not unrelated to this one. So there's the question of

9 whether there's a sufficiency of payment for the pediatric

10 coverage that the plans are giving, which, of course, is

11 somewhat of a head-scratcher because it doesn't appear that

12 the pediatric coverage that plans are giving is super

13 generous.

14 And my related question has to do with that part

15 of the Essential Health Benefits package which, of course,

16 binds all health plans sold in the individual and small

17 group markets and, specifically, qualified health plans

18 sold in the marketplace. But the Essential Health Benefits

19 package paved the way, you know, in a tortured manner, but

20 it paved the way for a much more generous pediatric benefit

21 because pediatric benefits are recognized as a specific

22 sub-category of benefits.

1 So you have, you know, hospital care, maternity
2 care -- it goes down the list -- rehab care. Then you have
3 a package called pediatric care. Well, of course, children
4 are members of plans, and so they get hospital care and
5 rehab care and whatever.
6 So, clearly, what was contemplated was a benefit
7 design that could be enriched for children, and we do see
8 specific -- I mean, it says, "pediatric care, including
9 dental and vision care." So, clearly, what Congress wanted
10 at a minimum was vision and dental care.
11 But the word "including," of course, has real
12 legal significance. It doesn't say, pediatric benefits
13 "defined" as vision and dental. It says, "including."
14 And so I've, you know, continually come back to
15 these two related questions, which is: Number one, is the
16 premium weighting sufficient enough for children? And,
17 number two, could more be made out of the pediatric benefit
18 element of the Essential Health Benefits package to
19 essentially begin to administratively tackle the problems
20 that we discussed in the first hour?
21 And, you know, I think it's notable that we have
22 the Secretary's report on benefits in the exchange and the

1 2017 Notice of Benefit and Payment Parameters that appears
2 to do nothing to connect the dots here.
3 And so I would, you know, suggest that one of the
4 things we want to think about is connecting the dots, that
5 when you have a report that says our benefits are not
6 structured properly for children and you're doing your
7 Notice of Benefit and Payment Parameters, you use the tools
8 that Congress has given you, and you address both the
9 sufficiency of the premium and the design of the benefit.
10 And I think when we get to the discussion that
11 Trish previewed this issue of having tools in the tool box
12 to begin to do some things around benefit design in
13 qualified health plans really ought to be on the table.
14 COMMISSIONER MILLIGAN: I think I'm going to be
15 following the same track. My recollection of the community
16 rating part of exchanges -- and I could be mistaken, but I
17 think it was a 1:4. So the theory is for the same benefit
18 design you couldn't -- if a child's plan would be $100, the
19 most you could charge the higher age group for that same
20 benefit design would be $400, and you couldn't have a
21 broader range than that.
22 The view at the time was that the effect of that

1 would be kids would be subsidizing older people because if
2 you were actually rating, and not doing experience rating
3 but just community rating, most states that do age banding
4 typically have broader age bands than 1:4.
5 And so I do think that -- to Anne's comment about
6 why this is on the agenda today, I do think that
7 considering whether the age band rule is making the premium
8 for children more expensive than it ought to be in a way
9 that subsidizes premiums for older people, addressing that
10 as an affordability issue for a CHIP transition, I think,
11 is highly relevant because if it was a broader banding and
12 the premium was less expensive for the same benefit design.
13 I mean, it's a shift back to older people in the mix, but
14 that might be appropriate. And I do think that
15 contextually it's an area that we ought to be expressing
16 interest in.
17 COMMISSIONER RILEY: I think sort of a further
18 issue is we need to think about where the parents of these
19 children are. If they're in employer-based coverage and
20 these kids in CHIP plans have been -- if the parents are
21 okay, but the kids are in CHIP plans, can they then go and
22 buy a child-only plan? That's where the anti-

1 discrimination issues trigger. And how many of those kids
2 there are, I'm not sure, but I think it really does matter
3 where the parents are.
4 COMMISSIONER HOYT: The question she passed to me
5 was this issue around the age factor. Does setting the age
6 band necessarily increase the actuarial value? I'd say no,
7 it doesn't. That's not the way the actuarial value is
8 calculated.
9 That percentage is the percentage of the benefits
10 that the plan is expected to cover, that you just
11 purchased, but it doesn't reflect what you pay for that.
12 CHAIR ROWLAND: Let's move on, Joanne, to
13 Medicaid and CHIP premium assistance and basic health
14 plans.
15 And this was just FYI. This is not...
16 **### Analyses and Updates on Children’s Coverage:**
17 **Medicaid and CHIP Premium Assistance and Basic Health**
18 **Program**
19 * MS. JEE: Okay. Commissioners, in past meetings
20 you've talked about whether there are creative ways to use
21 public funds to bridge public and private coverage, health
22 coverage for children. In other words, are there

1 mechanisms that would help smooth the transition in terms
2 of what benefits are covered and the cost of getting
3 insurance and services so that as children move from one
4 source of coverage to another, they don't experience steep
5 cliffs?
6 Today I'm going to share with you some
7 information about coverage programs with bridging
8 mechanisms that may be helpful as you think about future
9 coverage for low- and moderate-income children. These
10 programs are Medicaid and CHIP premium assistance, state-
11 funded exchange subsidies, and the basic health program,
12 which is commonly referred to as BHP. Following a quick
13 overview of these programs, I'll highlight some questions
14 that come up and that will be important to consider.
15 The first program is premium assistance. You
16 will recall from earlier meetings and the March 2015
17 chapter on this topic that premium assistance is the use of
18 federal Medicaid or CHIP funds to purchase private
19 coverage, and this slide just presents a very high level
20 overview of the rules over premium assistance programs.
21 Prior to the ACA, premium assistance programs
22 focused primarily on purchasing cost-effective, employer-

1 sponsored plans. These programs could cover both children
2 and adults, depending on the state, and with respect to
3 benefits and cost sharing, Medicaid and CHIP rules applied,
4 which means that states have to provide wrap-around
5 coverage where needed.
6 You'll see that many states currently have
7 premium assistance programs, but that enrollment in those
8 programs is pretty low.
9 With the implementation of the ACA, states are
10 taking another look at premium assistance, but instead of
11 purchasing employer-sponsored coverage, they're interested
12 in purchasing exchange coverage. And you've heard about
13 those programs before. But quickly to recap, the states
14 also have to provide wrap-around coverage for benefits that
15 are not included in exchange plans or cost sharing above
16 Medicaid limits. However, states may seek waivers.
17 Currently, Arkansas is actively enrolling
18 individuals in its premium assistance program, which is
19 referred to as the private option, and New Hampshire's
20 program will launch on January 1, 2016.
21 Just a quick note about Iowa. Iowa recently made
22 a change to its program. One of the two exchange plans

1 withdrew from the premium assistance program, and the other
2 is no longer accepting new enrollees. And so the state is
3 now enrolling this population into Medicaid managed care
4 plans.

5 So there's relatively little new information on
6 how states' premium assistance programs are doing with
7 respect to serving their enrollees. However, much of what
8 was previously reported about the programs remains relevant
9 and important to think about if premium assistance is a
10 mechanism that you all might consider as a part of any
11 future bridge program.

12 First, wrap-around coverage is complex to
13 administer. States have reported operational challenges
14 such as obtaining needed information about what benefits
15 are covered and tracking and paying for cost sharing.
16 These issues may be somewhat more applicable to employer-
17 sponsored coverage because of the great variability among
18 those plans. Exchange rules provide for somewhat greater
19 uniformity in terms of benefits and cost sharing.

20 With respect to the wrap-around coverage in
21 exchanges, a national evaluation of 1115 waivers sponsored
22 by CMS is slated to provide information on states'

1 approaches for providing wrap-around, for example, EPSDT
2 benefits for 19- and 20-year-olds who are in the exchanges.
3 States have also reported that educating families
4 about premium assistance programs is challenging, for
5 example, explaining how the premium assistance programs
6 work and how to access wrap-around services when they need
7 them. And this is especially true for families with
8 limited English proficiency or low health literacy.
9 With respect to premium assistance for exchange
10 programs, evaluations of those programs are not yet
11 available, so the programs that are currently operating or
12 approved are approved under 1115 waiver authority, so there
13 is an evaluation required. But we don't expect that those
14 will be available for some time.
15 And just to go back quickly to the national
16 evaluation which I mentioned, in addition to looking at the
17 wrap-around benefits, that evaluation is to look at access
18 to care, outcomes, and spending as well. And for the
19 national evaluation, we expect an interim report sometime
20 in 2017 and a final in 2019. So we're still a few years
21 away from that.
22 The next bridge mechanism I wanted to discuss is

1 that of state-funded exchange subsidies. Four states --
2 Massachusetts, New York, Rhode Island, and Vermont -- are
3 providing these subsidies as a supplement to the federal
4 exchange subsidies. Now, these states are all state-based
5 exchange states, and they had previously expanded coverage
6 to adults prior to the ACA.
7 The state-based subsidies build on the federal
8 subsidies to provide additional financial assistance to
9 further reduce what enrollees must pay for their exchange
10 coverage. The details are in your meeting materials, so I
11 won't go through all of it. But I do just want to
12 highlight that states have taken a few different approaches
13 to providing their subsidies.
14 One way is to reduce the percentage of income
15 that enrollees must pay toward their exchange plan premium.
16 A second way is for states to pay the entire enrollee
17 share, which is what New York was doing. And just a quick
18 note about the New York supplemental subsidy program. That
19 program ends at the end of this year, which coincides with
20 the implementation of the states' Basic Health Program, or
21 the full implementation of that program.
22 And, lastly, Rhode Island is providing enrollees

1 a set dollar amount which is based on their family size and
2 income, and that dollar amount is then applied to the cost
3 of the premium.
4 In addition to premium subsidies, Massachusetts
5 and Vermont also provide additional cost-sharing subsidies.
6 However, unlike the premium subsidies for which the states
7 receive a federal Medicaid match, there is no federal
8 Medicaid match for the cost-sharing subsidies.
9 Lastly, the Basic Health Program, or BHP, was
10 created by the ACA to be a bridge program. Under this
11 option states can cover individuals with income from 138 to
12 200 percent of the federal poverty level, who are citizens
13 or lawfully present aliens, that are not eligible for
14 Medicaid or CHIP or affordable ESI or other minimum
15 essential coverage.
16 Rather than enrolling these individuals into
17 exchange plans, the states can enroll them into what is
18 referred to as a standard health plan, which at a minimum
19 must provide the ten essential health benefits. Premiums
20 and cost sharing are permitted, but they may not cost
21 individuals more in the BHP than they would have in the
22 exchange.

1 2015 was the first year that states could
2 implement their BHPs, and so far two states -- Minnesota
3 and New York -- are doing that.
4 I wanted to note, just to go back to benefits and
5 out-of-pocket costs, that the rules on -- the BHP rules
6 sort of set the minimum, and states can do more. So, for
7 example, on benefits, a state could negotiate with a plan
8 to provide more than the ten EHBs, or it could provide
9 supplemental benefits for BHP enrollees. For example, in
10 Minnesota's BHP, enrollees under age 21 get the Medicaid
11 state plan benefits, and adults receive the Medicaid state
12 plan benefits with some limitations and some exclusions.
13 And, similarly, on out-of-pocket spending, states
14 can lower what enrollees spend to purchase their coverage.
15 For example, in New York, BHP enrollees under 150 percent
16 of poverty have no premiums and Medicaid-level cost
17 sharing. And those who are above 150 percent of the
18 federal poverty level have a $20 premium and cost-sharing
19 levels that are higher than Medicaid but lower than the
20 standard silver exchange plan.
21 So, Commissioners, the programs that we just
22 talked about are not specific to children. I wanted to

1 note that. But they are examples of bridge programs that
2 are currently in place in states. We raise them to you in
3 case there are aspects of these programs that might be
4 helpful or informative to you or that could be built upon
5 for any future design for children's coverage. If you do
6 intend to consider them, there are a number of questions
7 that ought to be considered.
8 Are any of the mechanisms feasible or suitable
9 for a future design of children's coverage? And are any
10 one of them preferable? How would the mechanism interact
11 with existing federal exchange subsidies? Are particular
12 groups of children best suited for any of the mechanisms?
13 And what could be done to streamline program
14 administration?
15 What level of family or employer contribution
16 would be appropriate? And what would the financing
17 structure look like? And what would the federal and state
18 responsibilities be?
19 If you have any questions, I'd be happy to take
20 them.
21 CHAIR ROWLAND: Joanne, I was mentioning to Anne
22 another model that I think you could look at, which is for

1 the HIV/AIDS population, the wrap-around and interaction of
2 the benefits that the Ryan White ADAP program is able to
3 provide, because it really does sort of help with both the
4 premiums, the cost sharing, and with the uncovered
5 services, if there are any.
6 COMMISSIONER COHEN: Great job, Joanne. So this
7 is to me, I think, sort of heading into the meat and the
8 heart of the questions that Trish was also raising earlier
9 today about sort of what are some alternatives for
10 children's coverage that don't have the cost-sharing
11 challenges that the exchange would for children who are
12 near poor, you know, but that sort of are better aligned
13 with the system that we have for families. And I think
14 these are great questions, and I just wanted to raise a
15 couple sort of points or observations based on what you
16 said.
17 So one is I think it will be -- we may not have
18 the luxury of this time, so I'll probably give you my
19 anecdotal observation that you can credit as little or as
20 much as you want, but it will be -- you know, there have
21 been some, I guess, evaluations or some documentation of
22 the challenges of doing wrap-arounds under old programs

1 where you kind of had -- like you had to take one family's
2 employer-sponsored coverage that was idiosyncratic -- like,
3 looked like whatever it looked like, and then a state
4 person had to figure out how to kind of wrap around that,
5 and, you know, it was sort of complicated, and you were
6 mostly sort of doing it one family at a time. And that is,
7 I would argue, probably not that analogous to a program we
8 might envision where you take sort of more or less
9 standardized, you know, sort of middle-level coverage and
10 wrap around it for a large group of people. So I just want
11 to be very clear that that past experience may not,
12 depending on the design, be particularly relevant, and I
13 did want to say that in New York, the wrap-around
14 experience for what was a waiver program called Family
15 Health Plus that allowed parents and childless adults to
16 get Medicaid coverage for many, many years, and they
17 converted that into a wrap-around in the exchange. And,
18 again, anecdotal accounts, it has gone extremely smoothly.
19 Most people, you know, have not really experienced -- may
20 not even know about the change that's been very, very
21 smooth. And part of that is actually because many of the
22 same plans that operate in the exchange also operate in

1 Medicaid, and it's a high managed care state, so I realize
2 that's not necessarily applicable everywhere. But it will
3 be useful to see some documentation of that experience,
4 because I think there is, like, a bit of a gut feeling that
5 wrap-arounds are really complicated and hard, and it may be
6 that the facts are changing because the design of the
7 programs are changing. So that was the main point that I
8 wanted to make.
9 In terms of -- I will throw out some opinions
10 about some of these other questions. I would be strongly
11 disinclined to really try to think about particular groups
12 of children other than by income, you know, sort of being
13 best suited for any one of these programs. The whole
14 purpose of having sort of universal coverage, I mean,
15 nobody knows what conditions a child is going to have, you
16 know, in two days, much less in two hours, and I don't
17 think that we've gotten any evidence really to suggest that
18 we should have any clinical differentiation or otherwise,
19 like that that's really appropriate for children who are
20 sort of -- unlike adults where you might say there are
21 clearer pathways, you know, of -- or conditions that you
22 know are never going to sort of ameliorate or anything like

1 that. That is not true for children. And I think I'll
2 leave it there.
3 COMMISSIONER CHECKETT: Well, my comment is
4 actually -- you know, I certainly agree with Andy's. I
5 think this certainly is in keeping with the work that the
6 Commission has been doing, and I felt it was one of the
7 things that -- the first great recommendations we made in
8 terms of CHIP, and it's a pleasure to see the discussion
9 continuing to evolve.
10 So my comment will just be another question, and
11 I have no solution here. But I think that the Commission
12 going forward should also be looking at the impact of the
13 Section 1332 or the Wyden waivers, which Trish and I were
14 chatting about earlier. I know I read yesterday -- I think
15 I read yesterday -- it could be a blur -- that
16 Massachusetts has announced their plan to go after a
17 Section 1332 waiver to basically overhaul how health care
18 is delivered. They want to address the family glitch.
19 They want to address some of the disparities that resulted
20 from the ACA. And so that will be a whole new topic,
21 Joanne, for you or someone else. But, you know, it may be
22 that therein lies the answer and that it may really be an

1 overall full-scale reform at the state level that looks at
2 finally all the government-subsidized sources of health
3 insurance. So just a comment.
4 COMMISSIONER MILLIGAN: I had a question or two
5 on Slide 5, Joanne. The states that are doing some form of
6 supplemental subsidy, that are getting federal match, what
7 is the authority for the federal match? I mean, just a
8 little bit more detail about that, and then I might have a
9 follow-up question or so.
10 MS. JEE: Sure. They're each doing it under 1115
11 waiver under the designated state health program, the DSHP
12 programs. And, you know, they largely are -- these are
13 states that had previously expanded, and so they are
14 basically, I guess, converting sort of what they were doing
15 into these state-funded exchange subsidies.
16 Massachusetts specifically, because they had
17 their previous -- their pre-existing coverage in that
18 state, they wanted to make the affordability threshold look
19 the same for those enrollees, so they had to -- you know,
20 those enrollees were going into their new exchange to match
21 the ACA requirements. But because of the difference in the
22 affordability standard, they felt that they didn't want

1 their enrollees to experience that.

2 COMMISSIONER MILLIGAN: It hadn't occurred to me
3 as a variation on a theme about this, but hypothetically,
4 if a state could access federal match, whether it's
5 Medicaid or CHIP, at the matching percentage, and let's say
6 up to 200 percent of poverty, that would be a different
7 mechanism of sort of bringing down the out-of-pocket
8 related to QHPs. And so I think that as a tool for when we
9 have to take up the issue of the future of CHIP, you know,
10 sort of the framework that Trish mentioned earlier, a
11 variation on that theme is -- and I realize it's not a
12 national model, and there will be a lot of state
13 variability. But one of the themes could be availability
14 of matching funds to subsidize or provide financial support
15 around the premiums and cost sharing.

16 COMMISSIONER ROSENBAUM: I assume that's what you
17 were referring to, about using CHIP to provide advance
18 premium tax credits, potentially more cost sharing
19 reduction.

20 COMMISSIONER MILLIGAN: Well, and I think, to me,
21 one of the insights about this -- in this context is there
22 is a state match obligation, and so if it was available, it

1 may not be taken up by everybody in all the state budget
2 considerations, but it would then provide a tool that could
3 have -- and, again, if it was up to 200 percent of poverty,
4 it could sort of soften some of the national variability of
5 CHIP programs as they exist today.
6 COMMISSIONER ROSENBAUM: I assume you could also
7 repair the family glitch with it. I mean, it's the same --
8 COMMISSIONER MILLIGAN: So, I guess I did --
9 right. I wanted to draw attention to the fact that a
10 matching form of subsidy around the out-of-pocket, which
11 apparently is available in a couple of states through an
12 1115, could be an alternative inside the Act itself.
13 COMMISSIONER CARTE: So, Andy, maybe I missed it,
14 but if you can elaborate or backtrack, why did New York
15 choose to do both the Basic Health Program as well as
16 premium assistance in its change?
17 COMMISSIONER COHEN: No, actually, the premium
18 assistance was, like, a bridge to the basic health program.
19 COMMISSIONER CARTE: Oh, oh, oh.
20 COMMISSIONER COHEN: They were just doing too
21 many things and it took them an extra year to get that base
22 health program up and running.

1 COMMISSIONER CARTE: And the base plan covers the
2 adults, as well.
3 COMMISSIONER COHEN: Yes. The Basic Health Plan
4 in New York is actually only for adults.
5 CHAIR ROWLAND: But, the truth is, there are lots
6 of models out there that we can look at to learn kind of
7 where we're going and what to build on in the future as
8 opposed to just so structured in the past.
9 At this point in our deliberations, I wanted to
10 recognize anyone who wanted to make a public comment, and
11 then I'm going to ask the Commissioners, especially those
12 who are probably with us for the last time, to reflect a
13 little bit on their experience of being on the Commission.
14 **### Public Comment**
15 * [No response.]
16 CHAIR ROWLAND: All right. Well, then I might
17 start a little bit with some reflections, because it has
18 been a long road since December of 2009, when many of us
19 got a phone call saying, you've been appointed to this new
20 commission established by CHIPRA and you're going to look
21 at coverage for children and how to figure out how best to
22 provide coverage for children. CHIP is reauthorized, it's

1 a new day, with performance bonuses, and we want to look at
2 provider participation.
3 And we were all excited, I think, to join such a
4 commission, but then we found out that they forgot to put
5 any money in the legislation, so we were without an
6 appropriation until the Affordable Care Act passed.
7 And that passed in March of 2010 and we began our
8 journey, really, as a commission then, first by trying to
9 find some staff to provide us with the kind of information
10 we need.
11 And, I want to just reflect on the fact that we
12 really did, I think, build an incredible organization. We
13 built something that was not just a temporary one-year
14 commission to come up with some blue ribbon
15 recommendations, but an ongoing analytic and evidence-based
16 organization that could continue to, I think, give Congress
17 and the administration good advice about what to do and how
18 to proceed with the programs that so many millions of
19 Americans depend on in both Medicaid and CHIP, because the
20 ACA did also expand our mandate beyond children to really
21 look at the whole scope of the Medicaid program.
22 And, I think the framework that we have put

1 together is really evidence-based. We really do look at
2 some of the key issues for the program and provide
3 information for the federal government and for the states
4 that administer the program. But, I think we've also
5 always had at the heart of our deliberations that these
6 programs serve millions of low-income and very vulnerable
7 populations, and that's why we've had the discussion we
8 just finished about children.
9 So, I think we've gone a long way. We're a fully
10 functional organization. I want to thank our great staff
11 and especially our leadership from our Executive Director,
12 Anne Schwartz, who has really brought us to really a new
13 level of being able to provide data, information, and
14 analysis.
15 I also want to thank the fact that the staff is
16 so data driven and so research oriented and really does
17 take such a nonpartisan approach to our work and has
18 enabled us to build a reputation as a credible and
19 contributing research and resource policy center on
20 Medicaid and CHIP.
21 And, I want to really thank many of the fellow
22 Commissioners, those who will be departing, our new members

1 who came on board and really joined in the team as quickly
2 as possible. I know we've been trying to get GAO to change
3 the terms of our appointments, but your -- the new class
4 really showed that you can get up to speed quickly and we
5 really do appreciate the fact that you had very little
6 learning time to come on board.
7 And, of course, the terrific staff and especially
8 Anne. I personally have been very proud to have worked
9 with this organization and to work with all of you. I
10 think we leave a really great legacy from the inaugural
11 class. We have one more set of inaugural Commissioners to
12 go through, but this has just really been for me a very
13 important and wonderful contribution to public policy for
14 people who have often been left with no voice in public
15 policy. And, so, we do really work, I think, to try and
16 understand the complexity of all of these issues, because
17 they are complex populations, but I hope that as we go
18 forward in the future, Patty's admonition to say, just,
19 please, make it simple, make it understandable, and maybe
20 even make it federal, should be things that the Commission
21 considers.
22 And with that, I'll turn to the departing

1 Commissioners for any reflections they may have.

2 COMMISSIONER ROSENBAUM: Before you turn to the

3 departing Commissioners, you cannot jump over yourself that

4 quickly.

5 COMMISSIONER RILEY: That's right. That's where

6 I was going --

7 [Simultaneous discussion.]

8 COMMISSIONER ROSENBAUM: So, those of us who are

9 hanging on for another year, not to mention those of us who

10 are here now for several more years, I think that it is

11 very important for the public record to say that there will

12 be many chairs of MACPAC, as there should be, because it's

13 an institution and it goes on and that's the nature of

14 institutions, that they require -- they acquire chairs and

15 they acquire members. But, there will always be the first

16 chair, and I think the first chair has, you know, a job

17 unlike anybody else, because, you know, it's like George

18 Washington was the first President. Somebody had to be the

19 first President and it was George Washington and here we

20 are.

21 I think that, really, Congress owes you a debt of

22 gratitude. I know we do, as the Commissioners, for the

1 really incomparable job you have done as Chair.

2 [Applause.]

3 CHAIR ROWLAND: Thank you. Thank you. It was

4 really fun to start with no money, no staff.

5 [Laughter.]

6 CHAIR ROWLAND: And, really, no agenda, except

7 the thousand things the Congress wanted to know.

8 COMMISSIONER RILEY: I'm actually reminded of the

9 first meeting when we met with Congress, and as I recall,

10 the majority and minority wanted to meet with us

11 separately, and they did, and they told us profoundly

12 different things and asked for profoundly different things,

13 and, in fact, asked for things that really countered the

14 other. And, so, there we were, left with really

15 conflicting guidance about what the Congress wanted, no

16 agenda that was very clear in the statute, and I think,

17 again, to your leadership, we were able to really craft an

18 agenda and make, I hope, a substantive difference.

19 And it's really been, I think -- I suspect we're

20 all going to say the same thing, that, you know, we've

21 formed this great community and it's really quite

22 phenomenal to think of where we started and how we

1 struggled over that visual about what our -- you know,
2 remember that thing, that visual about how to think about
3 how to think about our work. And now --
4 CHAIR ROWLAND: That was part of what they used
5 in the original access rule.
6 COMMISSIONER RILEY: I know. I know. But it's
7 been just such an extraordinary, and I think it's been, for
8 me, a great community, lots of learning from each other,
9 but the staff is just phenomenal and it's only as good as
10 its leader, so hear, hear to Anne and all the work. It's
11 been great. And I hope there's an alumni association.
12 COMMISSIONER CHECKETT: See me later.
13 [Laughter.]
14 COMMISSIONER CHECKETT: So, no, I would just
15 chime in, too, and I always like to kind of look back from
16 whence we've come. And in addition to just having an
17 opportunity to continue to work on such an important
18 program, at a time, really of -- you keep saying
19 unprecedented growth, and it keeps being more unprecedented
20 each year.
21 But, I've learned a lot. I'm profoundly grateful
22 to the friends and people that I've had a chance to work

1 with over the past six years.

2 I think it's important to recognize that there is
3 actually a phase in which our first Executive Director, Lu
4 Zawistowich, and Diane, I believe, were working out of Lu's
5 kitchen, trying to persuade people to come work for MACPAC
6 as staff, even though it only had a one-year appropriation,
7 and, you know, convincing people that this was really going
8 to turn into something, and it has. I could not be prouder
9 of it.

10 And, I also just have to echo, in particular, to
11 Anne and the staff, fantastic work. It's been great to
12 watch you guys grow, and some of you, I will miss in
13 particular.

14 But, in particular, Diane, my gratitude is to
15 you. And what my observation is, is that in our kind of
16 early struggling days, that it was your reputation for who
17 you were already as a professional in this field that
18 really, one, kept us going, and, I think, also just gave
19 the credibility and cover that we needed. So, thank you
20 very much and thanks to everyone. It's been a lot of fun.

21 CHAIR ROWLAND: Patty.

22 COMMISSIONER GABOW: [Off microphone.] Well --

1 [Laughter.]

2 COMMISSIONER SZILAGYI: She's got four points.

3 [Laughter.]

4 CHAIR ROWLAND: Keep them simple.

5 COMMISSIONER GABOW: Well, from my perspective,
6 it's been an honor to be part of this group, and it's been
7 one of the highlight experiences, I would say, of my
8 career, and I've appreciated what I've learned from
9 everybody. And, I've learned so much from the other
10 Commissioners, become friends with them.

11 I think what's been interesting as we grew is
12 that, clearly, while we weren't all coming from the same
13 place or the same perspective, but everyone was open,
14 respectful, and helped us see the other side of some of the
15 issues and that was wonderful.

16 I would echo, it's been wonderful to work with
17 Diane, and Anne has been wonderful. The staff is terrific.
18 And, I think, as others have said, you know, I think the
19 work has been great, and it's evolved, which shows that
20 we're a learning enterprise, which I think is really
21 important, because you never can come out of the chute with
22 everything you need and everything you want to be, and I

1 think we've really grown to have really great work.

2 And, for me personally, I've always been
3 committed to the underserved, and when I retired from
4 Denver Health, there was sort of a vacuum about where do
5 you stand to be able to continue to work on that and this
6 was a great opportunity. And now that I won't be standing
7 here anymore, I intend to cry.

8 [Laughter.]

9 COMMISSIONER GABOW: But, it's been wonderful and
10 I thank everybody for being able to be part of it.

11 CHAIR ROWLAND: Mark.

12 COMMISSIONER HOYT: Well, I, too, thoroughly
13 enjoyed my tenure on MACPAC. It's been one of the
14 highlights of my career, as well. This is, without a
15 doubt, the smartest group of people, including the staff,
16 for sure, that I've ever sat with to discuss Medicaid and
17 CHIP.

18 When I got my invite to come to the grown-up
19 table six years ago, I thought, well, I've got 25 years of
20 Medicaid experience under my belt. I ought to be somewhat
21 solid, at least in some areas, weaker in others, maybe a
22 few deficits here and there. What hit me pretty early on

1 is I don't have deficits. I have, like, chasms. There's,
2 like, so much about this program, still. It's so broad and
3 wide and deep, things that I didn't understand.
4 So, some topics, I was able to -- I was worthy of
5 wearing the MACPAC jersey and could make decent comments,
6 and then other times, I was just out of my depth and
7 probably didn't function as any more than actuarial eye
8 candy.
9 [Laughter.]
10 [Simultaneous conversation.]
11 COMMISSIONER HOYT: That's probably why we need
12 17 Commissioners. So, thanks.
13 CHAIR ROWLAND: And Steve.
14 COMMISSIONER WALDREN: Sure. It's really been a
15 pleasure. I almost think of my experience here as kind of
16 like "The Matrix." My understanding of Medicaid before I
17 came was the joy and challenges of taking care of the
18 patients that had Medicaid. For some reason, I've decided
19 to take the red pill and not the blue pill and now I
20 understand the complexity and the byzantine nature of the
21 program and have a really great respect for the policy
22 framework and a lot of people who have worked in this.

1 I really appreciate the staff. I don't think we
2 could do anything that we do without the staff. It's just
3 been a stellar -- and I didn't think I was going to get
4 friends out of the mix, but I'm glad that I do and look
5 forward to keeping up with folks. Although I don't do
6 Medicaid, it's really been a pleasure to be part of this
7 group.
8 CHAIR ROWLAND: Okay. Well, thank you. Thank
9 you all for everything you do and for all the work you have
10 put into this Commission. And, again, maybe another round
11 of thanks and applause for Anne and the staff, who really
12 make us look smart.
13 [Applause.]
14 CHAIR ROWLAND: And, so, we adjourn for today.
15 Thank you.
16 [Whereupon, at 4:30 p.m., the meeting was
17 adjourned.]