PUBLIC MEETING

Ronald Reagan Building and International Trade Center
The Horizon Ballroom
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Thursday, January 25, 2018
9:17.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[9:17 a.m.]

CHAIR THOMPSON: All right. We'll get started. We have an exciting agenda for today, and we're going to get started off with Nevena Minor and Erin McMullen talking about 42 CFR Part 2 regulations.

42 CFR PART 2 REGULATIONS AND IMPLICATIONS FOR SUBSTANCE USE DISORDER TREATMENT AND INTEGRATION WITH OTHER MEDICAL CARE IN MEDICAID: THEMES FROM EXPERT ROUNDTABLE

* MS. MINOR: Hi. Good morning. As part of exploring Medicaid's role in substance use disorder treatment, MACPAC has identified the need for improved integration of physical and behavioral health services and noted that the federal 42 CFR Part 2 regulations which govern the confidentiality of substance abuse treatment records may act as a barrier to information exchange between providers treating Medicaid enrollees.

We first discussed this in a chapter in the March 2016 report to Congress on the fragmented delivery system for behavioral health and again in the June 2017 report, which included a chapter focusing on Medicaid responses to

the opioid epidemic.

So today's presentation begins with a bit more detail on 42 CFR Part 2. We call it "Part 2" for short. We then summarize the themes that emerged from an expert roundtable MACPAC convened in November which sought to illuminate in more detail Part 2's effect on Medicaid and potential ways to address identified challenges. We hope that these points can inform your discussion and considerations on potential further Commission actions.

So as you know, HIPAA governs the disclosure of individually identifiable health information. Generally, patient consent is not required when providers want to disclose information to others for purposes of payment, treatment, and health care operations. However, in the case of patient records, with SUD treatment or prevention information, Part 2 takes precedence. Part 2 predates HIPAA and implements laws that were originally passed in the 1970s and which were intended to address the stigma of SUDs and encourage individuals to seek treatment who otherwise may fear harmful consequences such as criminal prosecution, employment, housing, or child custody loss or insurer discrimination.

The Substance Abuse and Mental Health Services Administration, SAMHSA, most recently updated the Part 2 regulations in 2017 and 2018 in response to health care delivery changes around electronic information exchange and care integration.

So Part 2 permits disclosure without patient consent in far fewer circumstances than HIPAA, and absent a court order, law enforcement is barred from accessing information.

So SUD treatment providers subject to Part 2 -- and I will explain on the next slide who is meant by that -- need to secure written patient consent to make a disclosure of SUD-related information to any other person or entity. This includes disclosures to Medicaid MCOs for payment or disclosures for treatment such as if you're referring to another provider or an entity that's assisting in care coordination. The recipient of any such information generally can't further share that information unless there's a new separate patient consent.

There's only limited circumstances under which consent is not required, and this includes cases of medical emergency or for communicating with a qualified service

organization, and that means that -- a QSO is an entity that provides administrative or professional services to the Part 2 provider, such as billing services or legal services.

So SUD information is subject to these more stringent consent requirements only when it's delivered by a provider subject to Part 2. So that's a provider that's federally assisted and who meets the definition of a program. And "federally assisted" is defined very broadly, and it includes anyone receiving federal funds. And "program" is defined as an individual or entity other than a general medical facility or an identified unit within a general medical facility that holds itself out as providing and does provide SUD care. Or it could be a staff in a general medical facility whose primary function is SUD care and who's identified as such. And "hold itself out" is defined as an activity that leads one to a reasonable conclusion that the provider delivers SUD care, and that could be because they advertise for such care, they're licensed to deliver such care.

So in light of the Commission's previous identification of Part 2 as a barrier to whole-person care,

we convened a roundtable of expert stakeholders to better understand Part 2 protections, why they're needed, how it affects care delivery in Medicaid, and what changes may be needed to support care integration while maintaining important patient protections. The roundtable was held in November 2017 and included 16 participants representing federal and state Medicaid and behavioral health officials, legal and behavioral health experts, Medicaid plans' providers, and patient and family advocates, and Commissioner Kit Gorton attended as well.

I'll turn it over to Erin now to present the themes that emerged during the roundtable.

* MS. McMULLEN: Thanks, Nevena.

The roundtable findings can be categorized into five different themes. The first theme that quickly emerged during our discussion was the disclosure of patient substance use diagnosis or treatment status could expose them to significant harm, particularly when that information was shared outside of the health care system. Participants described numerous instances where individuals may be charged with a crime, lose their job, or lose custody of their child if Part 2-protected information was

shared with relevant authorities.

However, discrimination against people with substance use disorder wasn't limited to outside the health care system. Participants reported instances in which physicians would no longer see a patient whose substance use diagnosis was disclosed. As a result, advocates did stress during our roundtable discussion the importance of preserving patient choice and autonomy about whether to share substance use treatment information with providers.

The second theme that emerged was that sharing substance use information within the health care system is important to integrated care, and when information sharing is limited, patient harm may occur. However, there were differing opinions amongst patient advocates and providers about the extent to which sharing information should be done within the confines that currently are required by Part 2. Providers described challenges delivering care when they only had a portion of an individual's health record. Some of those challenges are listed out under the second bullet on the slide. And several participants also raised concern that Part 2 perpetuates stigma by giving the perception that substance use treatment is different from

the rest of medical care.

The third theme that we found during the roundtable revealed that there was tremendous uncertainty about when Part 2 applies and to whom it applies. Participants noted confusion about when a provider or program is subject to Part 2, which patients are covered by the regulations, what part of their health care record is covered, and then whether or not substance use information could be shared within a program or with payers.

Even when it was clear when Part 2 applies, participants cited a great deal of confusion regarding what information needed to be included into a Part 2-compliant consent form in order to share treatment information with other providers.

As a result of this general confusion, we found that decisions by a program as to whether Part 2 applies to them and which patient records are affected can be arbitrary or inconsistent across the health care system. Participants noted that obtaining consent was also administratively burdensome.

During the roundtable, it was frequently noted that attorneys, even sometimes within the same health care

system, had different interpretations on Part 2's application, and overall there was agreement that regulations were complex and there was little guidance from the federal government on its application.

The fourth area that emerged from the roundtable related to technological barriers to the sharing of Part 2-covered information. In instances where a patient has given their consent to disclose treatment information within the health care system, there's two different issues that were identified which hinder the ability to share treatment information electronically.

So, first, many community-based substance use treatment providers have not adopted EHRs at the same rate as the rest of the medical system. Participants noted that many of these providers continue to share information by paper, phone, or fax. The roundtable discussion also attributed the slow adoption of EHR to a lack of financial incentives. Substance use providers were not eligible for financial incentives under HITECH that the rest of the health care system was able to access.

Second, most EHRs and health information exchanges are not built to segment substance use treatment

information from the rest of someone's clinical record. So Part 2 requires the consent form to contain explicit descriptions of the types of substance use treatment records that a patient chooses to disclose. Therefore, when consent is given, an EHR and HIE has to be able to customize and segregate the substance use data to be shared based on the participant's disclosure preferences. So if a program did not initially set up their EHR to segment information this way, it might be difficult or costly for them to go ahead and make those modifications. Therefore, many EHRs and HIEs simply don't include substance use treatment information or providers aren't uploading their information to those systems.

In the absence of federal standards, requirements, and financial incentives, many of the participants at the roundtable felt that Part 2-covered information and substance use treatment providers will continue to be excluded from EHRs and HIEs.

And then the final theme that emerged through our discussion related to the negative effects of Part 2 on Medicaid delivery systems. Part 2 limitations on data sharing make it difficult to predict financial exposure or

to actively manage high-risk, high-cost patients. While the health care system is moving towards outcome-based payment, it's difficult to hold health care providers accountable when they have incomplete or partial information about an individual's health status.

Roundtable participants, including payers, providers, and one state Medicaid agency, described how entities assume financial risk for Medicaid populations knowing that they lack reliable substance use treatment information.

And with that, I'll turn it back over to Nevena.

MS. MINOR: So the roundtable's purpose was not to foster consensus on any specific changes to Part 2 that should or shouldn't happen, but it did identify several stakeholder ideas to address the challenges Erin described. So there were differing levels of agreement among the participants on the three approaches that we highlight here. The first two suggestions we present are within the context of the existing regulation, and those did enjoy broader agreement than the final approach that I'll present.

So in light of the confusion expressed by

participants about when and to whom Part 2 applies, participants agreed that additional clearer federal guidance is needed to improve understanding and implementation of Part 2 throughout the health system.

There was also discussion about streamlining the overall consent process such as by creating a model consent form to clarify exactly what information must be contained in the consent or that there could also be a universal consent that combines the requirements of both HIPAA and Part 2.

I'd also like to mention here that SAMHSA as part of the 2017-2018 updates to the regulations recognized the need and indicated plans to issue some sub-regulatory guidance on some of these issues and may consider additional rulemaking.

So along with that clarifying guidance, there was also broad agreement that more stakeholder education is needed about Part 2. Participants indicated that SAMHSA and CMS ought to jointly develop targeted education efforts and offer technical assistance. Also partnering with provider associations and other such groups to disseminate information was seen as a good way to reach relevant

stakeholders and ensure that the information is packaged in a way that, you know, each of the stakeholder groups can understand. And any educational component should also stress the importance of why getting consent is important for purposes of patient care continuity and integration.

Finally, there was also some discussion about harmonizing Part 2 with HIPAA to allow for disclosure without patient consent for purposes of treatment, payment, and health care operations. I do want to note, however, that less time was spent on discussing this approach during the roundtable compared to the other two, and there was considerably less agreement among stakeholders about pursuing this idea. It was also unclear how much, if any, potential alignment could be done through regulatory change versus requiring a statutory change.

Regardless, with any such effort, everyone recognized the need to maintain or strengthen protections against unauthorized disclosures and discrimination outside of the health care system.

So based on the information we presented here, we look forward to hearing your thoughts, and if the Commission has any interest in exploring whether to make

any recommendation addressing the identified challenges. We would value feedback on the types of information you would need to develop specific recommendations and to evaluate their merits.

Thanks.

CHAIR THOMPSON: Okay, great. I'm going to ask Kit to kick us off here, since you were present at the roundtable discussion, with some of your own observations and any questions.

COMMISSIONER GORTON: Sure. So as always, the staff did a wonderful job, and I have to say that it was a fascinating day. When I got there, I was expecting there to be sort of this very fractured, different points of view, competing kind of rhetoric because that's what you sometimes hear reported about interactions between the patient advocates and the provider community and others interested in how this works. And, in fact, what I came away with was, as staff presented, a real sense that there's a huge commonality of point of view with respect to a great deal around Part 2. Everybody agrees they're important. Nobody suggested they should be done away with. Everybody thinks that the protections are necessary.

But for me, the most striking thing is that there was unanimous agreement, including the regulators in the room from CMS and from SAMHSA, that the system is broken, it doesn't work, nobody understands it, and it should be fixed. And so I was struck -- I would just add two other detailed things to the information that Nevena and Erin have just presented.

First, there was a lot of discussion about this concept of breaking the glass. Part 2 is imperfect, and once information is disclosed, much like attorney-client privilege or doctor-patient privilege, once something's disclosed, it's out there. It no longer has Part 2 protection. And that can be if it's disclosed by the member or the patient; it can be if it's disclosed by some other third party. There's no way to wrap it back up again. And that's particularly an issue for these -- for the stigma piece because while Part 2-protected information cannot be included in criminal justice proceedings, it absolutely can be included in civil and administrative proceedings. So denial of a mortgage, child custody battles, bankruptcies, life insurance, all those things, it's fair game if it's out there. And so that really sort

of creates a problem, and the patient advocates talked about the work they have to do to educate patients and their families about how to keep the information protected. So that's a pretty tricky piece.

Based on that, I took the liberty of throwing together some straw model recommendations that I'll just offer. I'm not wedded to the wording, but I think in terms of broad topics, they might give us a starting point for things that we could talk about that I think had some consensus in the room.

So, first, as I mentioned, Part 2 is woefully misunderstood and misapplied. Nobody knows who it applies to. You know, we've got hospital ERs not sharing information with others even though ERs are not a Part 2-regulated entity and the information that they provide under the emergency exclusion is shareable information. So that kind of information sharing could be improved, and I would suggest that the Commission could recommend that the Secretary direct SAMHSA, CMS -- and the staff didn't mention ONC, but ONC has an important role to play here with respect to the EHRs and the construction of those kind of programs. Those agencies should develop coordinated

technical assistance to states' providers of all types on the purpose, reach, and exclusions from Part 2 protections.

The roundtable made it clear separate educational tools needed to be developed for consumers and families that talk about the extent and limits of privacy protections.

Second, as has been mentioned, Part 2 lacks sufficient operational guidance defining who the covered entities are, and so SAMHSA, CMS, and ONC should issue clear subregulatory guidance defining how covered entities are defined and identifying how their encounter data can be legitimately included in health care operational analytic databases without compromising the privacy rights of consumers and families. And there are ways to do this, but nobody is clear where the lines are drawn.

Third, Part 2 and HIPAA, as has been mentioned, intersect and overlap, and I think the Commission can recommend that in the interest of administrative simplification and regulatory streamlining, the Secretary can direct the agencies to harmonize and consolidate the regulations to clarify their application and ease the burdens of compliance so that people know which rules apply

in which circumstances, and there are just some basic administrative things that could be aligned without in any way diminishing the protections.

And, finally, as the staff noted -- I lost my note. Oh, so the statute dates from the 1970s, and it's been updated a little but not much. At that point substance use disorders were treated in stand-alone systems, records were paper-based. Now substance use disorder is being treated in integrated systems of care, records are electronic, and our understanding of substance use disorder as being a biologically based brain disorder has evolved. So Congress should consider legislation which could include advancing or amending bills which have already been introduced in the current session to modernize and enhance Part 2 protections so that consumers can seek their SUD treatment in the site and setting of their choosing.

And that was the other point that I wanted to bring up. The protections are different depending on where you get your care. If you get your buprenorphine from your family doctor, then Part 2 doesn't apply. And so understanding how that works and what applies in a

different section, different things -- if you get substance use treatment from an emergency room, Part 2 doesn't apply. And so the law should be shifted to make sure that people have the same level of protection across all elements of the delivery system, no matter who's delivering the care, not just necessarily in Part 2-regulated things.

And then the other thing that the law should do is not just protect the use of this information from criminal proceedings but also from civil and administrative proceedings, because people shouldn't lose their housing because they did the right thing and sought treatment for substance use disorder. People shouldn't lose their kids because they did the right thing and sought treatment for substance use disorder. And yet that is happening, as was reported to us, on a regular basis.

So, anyway, I think the Commission could take up one or more of those recommendations legitimately and it would be consistent with the feedback from the roundtable.

Thank you.

CHAIR THOMPSON: Thank you.

Okay. Let me see who else has comments. We have Martha. We have Alan. We have Kisha and Chuck. Martha,

Alan, Kisha, Chuck.

Let me just ask one question before kicking it off to Martha. I am a little confused when we talk about providers and then when we talk about plans, and so can you just speak a little bit about what happens inside of a plan and the access of information that a plan has to information from providers delivering services, including some of the entities that are covered under Part 2, and whether or not in a plan situation, we're talking about information not sharable among providers but sharable from the provider to the plan, and then what that means in terms of access to treatment and coordination of treatment?

MS. MINOR: So a plan can only get access to that information if the provider that's contracted with the plan has secured consent from the patient, so the provider needs to get the consent, and then provider can send that information presumably for purposes of reimbursement from the plan.

Once that information is at the plan level, the only way that the plan can share that information with anybody else without patient consent, if it's to a contractor or a subcontractor that is involved in helping

the plan fulfill whatever the reason was that they got the information in the first place, so this would presumably be for the purposes of payment. So that contractor/subcontractor can access that information as long as it's for just health operations and payment purposes, but the plan cannot -- absent separate consent, cannot share that information with, say, the patient's primary care provider because that would -- referral or follow-up or anything like that because that's considered treatment.

And if you're trying to disclose for treatment to somebody else, you need a separate consent form.

CHAIR THOMPSON: Okay. So the provider is going to get paid by the plan.

MS. MINOR: If the provider gets consent and --

CHAIR THOMPSON: Both.

MS. MINOR: Mm-hmm.

CHAIR THOMPSON: But the provider is going to get paid by the plan, right?

MS. MINOR: Only if they got the patient to sign the consent form to disclose it. Then the provider can go ahead and share the information and get paid by the plan.

CHAIR THOMPSON: So the provider can't get paid by the plan without the patient consenting to share the information, even though if the provider sent a bill to the plan, the plan would have an opportunity as a matter of program integrity, say, to evaluate the services provided to determine if that was appropriate?

MS. MINOR: But they would not be able to even bill for it because in that case it would be you would be identifying your patient as having an SUD, so you need to first get the consent of the patient.

CHAIR THOMPSON: I see. Okay.

Kit?

COMMISSIONER GORTON: Which leads to -- keep in mind that many of the Part 2 regulator entities get categorical funding, so they may not need to bill the plans. But what it does is it leads diminution of the completion of the datasets with respect to treatment people are getting. The thing is that providers, as was done back in the early days of the HIV epidemic -- providers use nonspecific codes that don't disclose anything.

So a PCP writing for buprenorphine can send a bill to a plan and not disclose, can use a nonspecific E&M

code and a nonspecific diagnosis code and get paid for their services. So there's a lot of dancing around.

CHAIR THOMPSON: Yeah. I mean, I guess from our standpoint, of course, we're focused on the Medicaid and CHIP programs and beneficiaries, and so those people are covered. And they're receiving services in many cases under managed care systems, and so it does seem to me that this issue about whether we're asking plans to serve people with incomplete information or asking plans to coordinate care for people and then not providing avenues for them to do that and whether or not there's something in the process of enrolling in a plan or being a participant in a plan that ought to be considered in terms of what kinds of patient consents are necessary for that provider network to share information and including, at minimum with the plan, about the services that are being provided is a reasonable question.

COMMISSIONER GORTON: The issue is that the way the statute is written, each disclosure requires a separate specific consent. So you can't prospectively consent -- you can't enroll in the plan. Even if you signed a one-time Part 2-compliant release of information, it doesn't

work on an ongoing basis, and so that would require a statutory change, was what I believe it is.

CHAIR THOMPSON: Very interesting.

All right. So we've Martha, Alan, Kisha, Chuck, and then Brian.

MS. CARTER: Kit, I want to thank you for the proposed recommendations.

First of all, I think it's very important that we clarify who's covered because I'm still confused. As an FQHC, it seems like we're not covered, but there are other parts of the regulation which would make it seem that we are covered, and there are lots of attorneys out there working on this for pay. We should clarify this once and for all.

I would like to strengthen perhaps one of the recommendations to affirmatively support integrated care models and whole person care. I think that's really important. That's best practice. People that are seeking treatment for substance use disorder, I believe are going to get the best treatment if they're in an integrated model, which means that their whole provider team knows their situation and understands the interaction of the

medications and their whole constellation of concerns. So I would strengthen what you proposed.

CHAIR THOMPSON: Alan.

COMMISSIONER WEIL: I just want to say I think this is really high-value work, and if we can make a positive contribution here, I would feel very good about the little tiny role I would play because I think it fits within so many of the issues we're addressing, and it seems actionable.

Kit, I very much appreciate your taking it the next step, and so just in terms of your questions, certainly with respect to clarifying what should happen, it sounds like an important thing to do and something that would benefit all actors in the system.

I don't know how much of an audience there would be for a technical assistance program, but anything that we can say that says this is not -- the ambiguities here are not helpful to anyone, including patients, I think that's an important statement to get across.

I will say, Penny, the answer to your question completely changed my understanding of this issue, and if true that a claim submission is a Part 2 violation by a

provider, again, I think going back to Kit's comments and, Penny, your answer, the provision does arise from a period where I would -- based on my understanding, the vast majority of these services were provided without a claim by entities that were not submitting claims. And so you wouldn't have thought of it that way, and the world is different. And that -- boy, I mean, that seems like a can of worms we ought to open because that, again, can't be good for access if that's a problem.

So before you asked the question, I was going to suggest we sort of stick with the easy stuff, if you will, and I'm not sure we're really ready for the tough conceptual tradeoff around confidentiality and integration, which there are strongly held views on both sides. I'd love to see a conversation that took that a step deeper, but I was sort of hesitant to feel much confidence it would bear fruit.

But this more recent -- after I put my hand up -- discourse makes me think that's an area where, again, it just sounds to me like leaving things where they are is a bad idea, and that might -- without sort of trying to take on the entire tradeoff between confidentiality and

integration, this might be an entry point where it's possible to find something that we could make a concrete recommendation on.

I just think this is really important, and I learned a ton and would feel very good if we could keep this on the agenda.

CHAIR THOMPSON: I also think just pulling on that thread just a little bit more that it provides a way for us to bound the issue to one that is appropriate for this Commission, focusing on the Medicaid beneficiary, the kind of delivery system that they're in, the reason that we're using those delivery systems, and how these rules may create some conflicts in the ability for those delivery systems to be successful in accomplishing what we expect them to accomplish.

Kisha.

COMMISSIONER DAVIS: I think just to the point of the complexity of it all as a primary care physician who provides substance abuse treatment for patients, it's interwoven into their care, right? So I see a patient, and I manage their diabetes and their thyroid disorder and suboxone all in the same visit. There's no way to really

separate that out on the claim.

And so as much as that can be integrated -- and to Martha's point, it's very important for the entire treatment team to be able to have access to that and be aware of what's going on so they can provide the best care for the patient.

HIPAA, I think does a fairly good job of that in terms of allowing the health care team to communicate amongst itself by signing that one release. It's very specific in terms of what you can and what you cannot share, and that there has to be a relationship. And so Part 2 could start to model some of those behaviors.

I don't know if it gets to the civil implications, although with HIPAA, it's supposed to be just limited to the treatment and care and billing for the patient. And so trying to model things more around that might be a way to help keep it within the health care community, who needs to be aware, and outside of the general public, who may not.

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: I want to echo the comments that I think this is a huge contribution. This is

great work. And, Kit, I really appreciate your comments about the session.

I had a couple of things. The first is piggybacking on what Alan said. I think it would be helpful to, in the narrative, when we get around to this becoming a chapter in something, describe what constitutes consent by the patient because my speculation based on the conversation Penny started with is that when there's an intake form being done, when somebody presents for an appointment or presents for care, they're signing a release. It's my expectation they're providing history and allergies, and they're signing a release allowing the provider to the bill.

But I don't know what elements need to be in that for that to constitute consent, and so I think having a little bit of clarity of what elements are necessary to constitute consent, I think in general, that would be a helpful contribution as well.

Based on kind of what I've heard -- and so my second point -- and there's going to be a question in here is -- I think I'm more comfortable putting language around, directional language around whole-person care along the

lines of what Martha said because I do think that in my experience, one of the barriers to aligning everybody's incentives, including for the patient, is the barrier of not allowing disclosure within a treatment team. I think it has an impact on value-based contracting. I think it has an impact on kind of ACOs and emerging models. I think it has an impact on trying to get hospitals engaged in having financial incentives to work on the reasons people present at the ED, and helping them work with peer support, work with FQHCs, work with others, if you can't share information inside that model, recognizing the real-life implications of criminal justice and child custody and everything that's been mentioned.

My question is, was there a sense within the group when you had the roundtable, around whether disclosure within a treatment team with a lot of prohibitions wrapped around that treatment team's disclosure along the lines of HIPAA? Was there any consensus about any dimension of that? Because in the materials, you do talk about the patient harm that can come from nondisclosure.

I mean, there's the harm of disclosure with

criminal justice and child custody, but there's also the harm of nondisclosure in terms of polypharmacy and all kinds of other things that can happen.

So I guess the question I have is-clarifying Part 2 is partway there, but I think the next step would be-is there a consensus around a treatment team's information sharing model? And I'm just curious if there was any consensus, or if there was too much kind of disparate view of that.

MS. MINOR: And I'll let Erin, if she wants to supplement anything.

On the elements of a consent, just kind of going back to an earlier point there, the regulation does say there's nine elements to what needs to be in the consent form. I think there's confusion about when you're -- the patient, you know, is allowed to further specify how much of that SUD information can be shared. I think there's confusion about how granular that can get and then how do you manage that when you share it.

In terms of consensus around sharing within the treatment team, I think everyone at the roundtable agreed the importance about integrated care, whole-person care,

and the potential if information is not getting shared with certain members of the treatment team, it could lead to harm.

I think some of the patient advocates still express concern that even within the treatment team that they should be able to retain the right to not consent to the sharing of information. I think they mostly cited there is still -- even health care providers can be prejudicial against individuals with SUDs, and so they should kind of have the ultimate right to decide where that information goes. And I think that's where -- we talked about the importance about just general education, about the importance of consent, both across, I think, providers and patients, that more could be done about just explaining why it's important to provide consent because I think sometimes it's just not provided because it's administratively burdensome, the tracking of that.

But I think there was still some tension around just kind of like you would under HIPAA, you could just, you know, share it without needing to get patient consent each time.

MS. McMULLEN: The only thing that I would add is

I think the closest that we got to that was that third recommendation -- or not recommendation -- third area to address challenges, that harmonizing Part 2 with HIPAA, and that really wasn't an area that there was a ton of discussion about.

There was some interest from different players, but as Nevena said, there were still those concerns about letting an individual retain their right to who that substance use treatment information was shared with.

CHAIR THOMPSON: Okay. I want to start to wrap up. We have Brian, Marsha, and Martha wants to get back in.

It seems to me that we seem to have some, I think, consensus around formulating some recommendations around the coordination of all the federal players to reach out and to educate and some clarification around these issues.

It's interesting to me that without some of the clarifications, understanding the implications becomes a little bit more difficult, and there are a lot of pieces of this puzzle having to do with wanting to encourage people to seek treatment, wanting to protect patients' information

appropriately, wanting to care for patients properly, wanting to support plans.

So I think that at least in my view, based on this conversation -- and based on the fact that we've touched this issue with one roundtable, so there's a lot of different, other kinds of potential ways we could try to tackle understanding the issue more fully.

So I'd like the Commission to think about whether or not there's some additional kinds of research work that we might want to commission from the staff with whatever other resources could be helpful here or approaches could be helpful here to formulate some direction or some perspectives and insight on what it means to apply Part 2 in a managed care environment or in whole-person environment and integrated care environment, such as we are trying to create throughout the Medicaid program in the state.

So let me do Brian, Marsha, and Martha.

COMMISSIONER BURWELL: So I would like to support the sentiments that are being expressed about this is an area where I think that we could make a positive contribution. I also agree that this is an area where

there is a lot of confusion around, you know, how Part 2 is impacting information available about this population. So I represent the research and policy community that is doing -- I mean, there's a very large amount of work being done now to try to get better information about persons with substance use disorder, that primarily relies on insurance data -- claims data for Medicaid but also in the commercial world. But, honestly, I think there's a very poor understanding about the potential inaccuracies of that information because of suppression of certain information.

And a specific interest that we may want to include in our conversation is the T-MSIS data set and what items the federal government is giving to states about suppressing certain data elements because they are protected under Part 2. And so states may not be submitting that data to the federal government, and if the federal government is getting that information anyways, whether it has additional suppression of those data elements prior to releasing public use files. So I think that's --

CHAIR THOMPSON: Absolutely.

COMMISSIONER BURWELL: -- very specific.

CHAIR THOMPSON: Yeah. Let's put that on the agenda too, just have that conversation with CMS and look at the specifications with regard to T-MSIS, so that we have a clear understanding of that, for purposes of informing our own research conclusions but also more generally the uses of T-MSIS in research.

Okay. Then I have Marsha and Martha.

VICE CHAIR GOLD: I wanted to add myself to the other people commending you and the work -- and the panel on a really good, you know, discussion that rang true. In my previous life I'd done an evaluation of HITECH and I know that this Part 2 issue comes up all the time and it comes up in managed care, and it really gets in the way of a lot of things.

I was thinking about how we -- I mean, I think the challenge for us, as being a Medicaid Commission, how do we factor into this where is our standing and where can we contribute. I like the idea of focusing on the coordinated care implications for delivery, and I think that -- I think we probably need to go back to some statistics we had in previous reports, or we can generate or update, that talks about what a disproportionate role

Medicaid plays in some of these services, and therefore why it's important, as well as Medicaid is out in front of a lot of people with coordinated care, and why this is a barrier. I mean, I think we need to talk about the carve-out issues, because some of these considerations encourage carve-outs as ways around them, and that's counter-intuitive.

A couple of things I can suggest we do, one is I think it might be useful to talk to some of the people who are most active in trying to address these issues from a policy perspective, and saying, "Hey, our focus is Medicaid. What might we recommend that would be consistent with the broader way things are going," so we put ourselves in that setting. The other thing that potentially could be useful is getting some more concrete feedback from Medicaid managed care plans, particularly ones that take care of adults, and adults in the new eligibility group or in whatever groups, populations are there, is really important.

And also sort of distinguishing, which we've done before, the sort of -- well, I'll leave that out because I don't know if it's relevant to this versus mental health,

but the sort of chronic problems population versus the others and how they're treated.

But I'm not quite how we, you know, we make a recommendation. We certainly, at this point, have enough evidence to say this is really important to Medicaid and its ability to manage care, and how, in addition, we intervene in that. One is bringing evidence that that is the case, and making that to the policymakers, and then however we can lend our voice from a Medicaid perspective to things that help solve this seems useful.

CHAIR THOMPSON: Martha.

COMMISSIONER CARTER: Just a quick little bit of information. You all mentioned ONC a couple of times. My organization uses one of the top EHRs, outpatient-based EHRs in the country, and it pulls in all prescriptions from claims data, so the providers can see everything, unless the patient pays cash, in which case it is not recorded. So we really do have some kind of thorny issues here, because those data are flowing into the EHR and it's then accessible, at this point, you know, the buprenorphine or any kind of MAT treatment.

CHAIR THOMPSON: Okay. So great presentation,

great work, great discussion. Obviously the Commission very interested in continuing here. I do think it would be helpful if we could formulate some recommendations around the coordination and clarification issues, and then think of ways in which we can bring more light to our understanding and to the larger understanding of issues with coordination, integration of care, and particularly the context of a plan, providing services to a Medicaid beneficiary as well as other contacts.

Just because I think that there might be some particular interest in this subject among the audience, let me just pause for a second before we turn to our panel to ask if the public would like to make any comments on this subject or this discussion. Just come to the microphone if you would like to do that. As I suspected.

PUBLIC COMMENT

* MR. GUIDA: Yes, hi. My name is Al Guida. I am a representative of Netsmart Technologies. The company makes electronic health records for mental health and addiction providers.

I think our concern relates to the introduction of FDA-approved products for the treatment of substance use

disorder. Suboxone and Vivitrol are both FDA-approved products. Prescribing those products without fully understanding the entire drug regimen that the patient is taking presents a clear and pressing patient safety danger.

One last comment. It is our understanding that HIPAA prevents the flowing of protected health information to landlords, employers, life insurers, civil court judges. That specifically applies to, for example, other stigmatized health conditions – HIV/AIDS, gonorrhea, hepatitis C. So it is really hard for us to understand how it is that addiction information is somehow more stigmatizing than those conditions and would have negative implications in those settings.

Thank you.

CHAIR THOMPSON: Thank you.

MS. REID: Hi. My name is Deborah Reid and I am a senior health policy attorney with the Legal Action Center. The Legal Action Center is the only nonprofit law and policy organization in the United States whose sole mission is to fight discrimination against people with histories of addiction, HIV, and AIDS, or criminal records, and to advocate for sound public policies in those areas.

I will also be submitting my comments in writing, in their entirety, as well as any supporting information that I have with me.

Our comments reflect almost four decades of experience and expertise in applying -- interpreting the federal law and regulations at 42 USC Section 290dd-2, for all of those who want to use that for Jeopardy, and 42 CFR Part 2, and more collectively known as Part 2.

As discussed more fully in my written statement, the Legal Action Center's position that Part 2's confidentiality regulations do not pose a barrier to the integration of physical health and substance use disorder treatment, and strike the right balance between information-sharing and patient privacy in substance use disorder treatment.

New amendments made to Part 2 by SAMHSA in 2017, and this year, 2018, have made it easier to allow patient consent for the sharing of health information between substance use disorder and other health care providers. Many vendors, health care providers, and substance use disorder treatment programs do not understand these new amendments and how to utilize Part 2 as effectively as

possible. We recommend that SAMHSA develop frequently asked questions and other subregulatory guidance, provide trainings, and develop model forms and practices.

Secondly, substance use and mental health providers should be given the resources to obtain and install electronic health record systems. The federal government should mandate that all electronic health record systems be Part 2 compliant.

I have three points, three major points, and then I will conclude. First of all, patients and advocates support maintaining Part 2's core confidentiality protections. The Legal Action Center and over 100 national state and local organizations support Part 2's core confidentiality protections by agreeing with a set of consensus principles that reflect the continued importance of Part 2's privacy protections. They also reflect that the worst opioid epidemic in our nation's history requires us to do everything we can to increase the number of people who are in treatment for substance use disorders.

Thirdly, substance use disorder is unique among other medical conditions because of the criminal consequences that you all have discussed today, associated

with the disease and the rampant discrimination people face. Patients in substance use disorder treatment should be given the right to authorize the manner in which their records are disclosed. The effective integration of substance use disorder treatment with the rest of the health care system is important and can be done in accordance with existing confidentiality law and current technology, and Part 2 provides heightened confidentiality safeguards for patients where HIPAA does not.

Secondly, the technology currently exists to integrate substance use disorder treatment and exchange information while maintaining compliance with confidentiality law. As I mentioned before, SAMHSA amended the Part 2 regulations in January of 2017, to promote the integration of confidential substance use disorder information into general health records. SAMHSA made additional amendments to the Part 2 regulations this month, making it easier for contractors, sub-contractors and legal representatives to gain access to Part 2 information, for purposes of payment and health care operations, and audit and evaluations. Now patients can easily share their substance use disorder information with some or all of

their past, current, or future treatment providers -- and that's in reference to that treatment team you all were discussing -- and that includes non-substance use disorder providers, with the patient's consent, but without having to name every provider in the consent form.

There are software applications that exist, such as Consent to Share, that allow patients to share their health data and permit the integration of current electronic health records.

The most important point under this major theme is that HIPAA requires electronic health record systems to comply not just with Part 2 but with also heightened state confidentiality protections, in the areas of mental health, HIV and AIDS, reproductive health, domestic violence, and other sensitive health information. Hence, electronic health records would need to have this functionality even if Part 2 did not exist.

As mentioned, you know, substance use providers and mental health providers are not eligible for the upgraded incentive payments under the HITECH Act. That should be corrected.

The second theme, Part 2 does not prevent family

notification in overdose situations. Part 2 generally applies to treatment providers, health units, and facilities who provide specialty substance use disorder care. Part 2 does not apply to most other providers who see patients in general medical settings, even if that patient has a substance use disorder. Instead, providers should follow HIPAA's guidance on family notification and emergency room overdose situations. And I will refer you to an attachment for our of our FAQ sheets about confidentiality and overdose.

In conclusion, with our recommendations, when applicable, confidentiality federal and state laws are applied we support the integration of patient substance use disorder information with overall health systems. Part 2 is an essential component in encouraging people living with substance use disorder to enter and seek treatment.

Part 2's newly updated regulations should be given the opportunity to work. SAMHSA should develop additional subregulatory guidance, as I mentioned before, like FAQs, provide trainings, and develop model forms and practices. Health providers should be provided with training on Part 2, HIPAA, and other applicable federal and

state confidentiality requirements.

Substance use disorder and mental health providers should be given the resources to obtain and install electronic health record systems. The federal government should mandate that all electronic health records are Part 2 compliant. And lastly, replacing Part 2's confidentiality requirements with HIPAA's less-stringent standards would not only sufficiently protect people seeking and receiving substance use disorder treatment, instead, many patients' lives would be severely harmed, and as a result, countless individuals needing substance use disorder treatment would be discouraged from seeking it.

Thank you for your attention.

CHAIR THOMPSON: Thank you, Deborah.

All right. Let's take one more comment and then move on to the next panel, and we'll come back at the end of the morning with an opportunity for more comments if people would like some more time.

MR. GORDON: Much more quickly, my name is Stuart Gordon. I'm with the National Association of State Mental Health Program Directors. We are part of a 30-member or so

partnership that -- which includes health plans, providers of various types, hospitals, large organizations, that have been pushing for a change to the underlying statute.

I just wanted to clarify something about the most recent revision to the regulations. The preamble to that revision specifically states that they are not allowing sharing of information among treatment providers. They are only allowing sharing of information for operations and planning and they are liberalizing that type of sharing a little bit more, but there is still a prohibition among sharing information among providers without the patient's consent.

Thank you.

CHAIR THOMPSON: Thank you very much. All right. More on this to come. Thank you all. Thank you to the public for your comments, and we'll move on to the next session.

And for folks in the back, there are some seats up front if you care to try to find a little more comfortable perch.

[Pause.]

CHAIR THOMPSON: Okay, sorry we're getting a

little bit late going with this panel, but expect to see an equal amount of robust interest and conversation on this topic as well. We do have one of our panelists who is still car parking, as I understand it, so we will go ahead and get kicked off here.

I'm going to turn it over to Erin to introduce our panelists.

EXAMINING RESIDENTIAL SUBSTANCE USE DISORDER TREATMENT AND THE IMD EXCLUSION

* MS. McMULLEN: All right. Thank you. So now we're going to have a panel to discuss residential substance use disorder treatment and the Institutions for Mental Disease, or IMD, exclusion. This panel build on MACPAC's previous work on opioid use disorders that was identified in the Commission's June 2017 report to Congress.

As we discussed in our June chapter, the IMD exclusion poses a barrier to accessing care in residential treatment facilities. Since the June report was issued, there has been continued interest in some updates on this topic. GAO did issue a report on state funding of IMD services, and while there were no recommendations, the

report estimated that nearly half of all inpatient and residential substance use treatment facilities in 2015 were IMDs. It also found significant variation and treatment capacity across the states.

There has also been legislation introduced to either partially or fully repeal the IMD exclusion to increase access to treatment, and the President's Commission on Combating Drug Addiction and the Opioid Crisis also issued a recommendation that CMS should grant all states a waiver from the IMD exclusion to expand treatment access.

Since 2015, CMS has offered two different pathways for states to pay for residential substance use treatment in IMD settings. One is through Section 1115 waivers, and the other is through the in lieu of provision in the managed care regulations. The in lieu of provision, we did talk about it some at our October meeting, but it essentially allows MCOs to pay for alternative services in settings that are not in the state plan or otherwise covered by their contract, as long as those services are medically appropriate and cost-effective.

So eight states have received a waiver from CMS

through the Section 1115 pathway, and there's many additional states that still have pending waivers or applications to pay for similar stays in IMDs. Many states have also expressed their intent to utilize that in lieu of provision that I mentioned earlier.

Among other things, this was all discussed at our October Commission meeting. In addition, staff presented an overview of plans to identify state-level gaps in coverage of substance use disorder services using criteria that was set forth by the American Society for Addiction Medicine, also known as ASAM.

So we decided to use ASAM to guide our work because it was the most widely recognized clinical guideline for the treatment of patients with substance use disorder. It identifies five broad levels of services across the treatment continuum describing specific levels of care and an overview of recommended provider requirements.

At the October meeting, we also discussed assessing state-level gaps in ASAM Level 3 services first. This level includes four discrete services that are delivered in facilities that are staffed 24 hours a day,

many of which are IMDs. These levels of care have not been analyzed by MACPAC previously, and our panelists will discuss those in greater detail today.

Staff are currently reviewing state plans and 1115 waivers to document the coverage of these services, and to supplement that review, we're also doing selective outreach to certain states to understand how the IMD exclusion does affect their benefit design and, where applicable, ascertain how the in lieu of provision and the managed care final rule influences the delivery of services in their state. And we're also going to try to determine whether beneficiaries are having difficulty accessing these residential treatment services.

So despite all the interest that has been given to the IMD exclusion recently, there is little information regarding whether individuals with opioid use disorder experience greater treatment gains in residential settings or whether they can experience similar gains in outpatient treatment or if specific lengths of stay are associated with certain therapeutic gains. Even ASAM acknowledges that further research is needed to predict typical lengths of stay for residential substance use treatment.

This panel will provide information for the Commission to evaluate whether the IMD exclusion should be changed specifically by focusing on residential substance use treatment. Our panelists will speak to the clinical profile of individuals in need of this level of care, utilization management strategies to ensure they're ready to receive clinically appropriate treatment, and state Medicaid experiences in offering these services. Information on the panelists can be found in the third tab in your binder.

So our first panelist is Dr. Yngvild Olsen. Dr. Olsen is the medical director of the Institute for Behavioral Resources, Inc./REACH Health Services, a comprehensive outpatient substance use treatment center in Baltimore, Maryland. Dr. Olsen has 20 years of experience and currently serves on the board of ASAM.

Our next panelist is going to be Dr. Matthew Keats, who is the behavioral health medical director for the Commonwealth of Virginia's Medicaid program. He has 20 years of experience working in a variety of roles in managed care and managed behavioral health care.

Longstanding Commissioners might remember that

last March Dr. Keats' colleague, Dr. Kate Neuhausen, came and spoke to you about the state's new addiction and recovery treatment services benefit that was authorized through their Section 1115 waiver.

And then our final panelist is going to be Dr. Enrique Olivares, who is the director of addiction services for Beacon Health Options, a behavioral health organization with programs for Medicaid beneficiaries and other public sector populations in 25 states and the District of Columbia. In his role, Dr. Olivares serves as the addiction expert for Beacon Health Options' Maryland hub.

So, with that, I will go ahead and turn it over to Dr. Olsen to get us started.

* DR. OLSEN: All right, great. Well, thank you and good morning, and thank you for the opportunity to be here to talk about this.

You know, when I think about kind of the area of residential treatment, I really think of it as part of a continuum of care, a continuum where patients move back and forth from outpatient to residential to acute-care hospital and kind of around, and so the slide that I've put up really has this as a circle. And so one way to then kind

of characterize that is to think of the residential piece as part of a crisis kind of set of services and really where needing to match the intensity of the intervention and comparing that with the intensity of a person's symptomatology.

And so as Erin mentioned, the ASAM criteria really have developed a common framework for how we think about kind of this range of services, so I wanted to actually provide a couple of comments about that before going into kind of the symptomatology piece because I think it's important that we understand that the Level 3 residential services isn't just one thing. When ASAM created the criteria now over 25 years ago, they really did so because there was such a huge variability across states and across payers around who got services and what type of services in these residential settings. And so the ASAM criteria really provide a common framework and a common nomenclature now for describing kind of this continuum of addiction treatment and provides a comprehensive set of guidelines then for placement, continued stay, transfer of patients kind of between an outpatient and acute-care hospitals if that is what is needed for individuals who

have addiction and other co-occurring disorders. It's used in 30 states at the moment, and as Erin alluded to, the residential services actually spans four different levels of care, even within this kind of Level 3, all the way from the least intensive, which is the Level 3.1 or so-called halfway houses -- that's kind of an older terminology -- all the way up to Level 3.7, which is really the medically monitored setting. And withdrawal management, or what used to be kind of known as detox, really can be an adjunct to any of those levels of care with appropriate staffing, based on also the need and the type of withdrawal management that is being offered. I'm going to talk a little bit more about that.

So this is a very busy slide and I apologize because it is also very hard to see the small print, but I wanted to show this to you all essentially because these various different levels that have numbers to them also can be matched to other nomenclature that is often commonly in use. And so just kind of from a terminology perspective, I think it's important that we all understand kind of where this all fits, as well as then this graph gives you a little bit of sense of kind of what some of the staffing

patterns are in these various different levels of care across even the residential services.

And so to then move towards kind of the symptomatology piece, how do we actually then decide who and what level of severity of a person's substance use disorders actually then kind of gets matched to the intensity of the service and the different levels of care? And the way that ASAM went about doing this when they set up the criteria is to really think about kind of six different dimensions, so very much like diabetes, for example. So, you know, we have the Diagnostic and Statistical Manual now that gives us some spectrum of severity for substance use disorders, from mild to moderate, depending on how many diagnostic criteria somebody meets. But that doesn't necessarily tell you the severity at a given point in time which then actually would lead a professional to recommend a higher level of care, Level 3.7 that needs withdrawal management, versus kind of a lower level of care, like a 3.1.

So similarly to the way we think about diabetes, where people can have severe uncontrolled diabetes, but that doesn't necessarily give you the information you need

in order to make an assessment of whether the person needs acute inpatient care, can be managed in an outpatient setting, needs to go to an endocrinologist. So really this way of thinking about these dimensions kind of allows us then to actually get some more robust information around hat is that person's symptomatology at the time that we're really thinking about kind of this crisis level of care as well.

The six dimensions go through intoxication and withdrawal potential, especially looking at withdrawal from alcohol, benzodiazepines, which have mortality associated with them and significant morbidity from not only cardiovascular mortality but also seizures. Opioid use disorder withdrawal has potential for -- small potential for mortality, but it's much less than that from alcohol and benzodiazepines, for example, and I'll talk a little bit more about that in a minute.

Other biomedical conditions, so does the person actually have other contributing acute medical conditions that would need a different set of services? Emotional cognitive behavioral conditions, other psychiatric conditions, other -- how stable is the patient emotionally?

Readiness to change is something that is also important to assess essentially because in people who have a substance use disorder, often they don't access services, particularly residential services, because if they're working, then they're concerned about losing their employment. And so even if they meet the other criteria, they may not actually be at a point where they really are willing to accept that recommendation. So that's important to assess.

The dimension of relapse potential. Is the person -- and that goes along with kind of the recovery and living environment, because is the person at imminent risk of relapse? And what are the risks then of that relapse? So have they been in an incarcerated setting and now are at very high risk for relapse if they go back to an environment where everybody in their house is using, and if they have not actually been treated for their opioid use disorder, particularly with medications, in the incarcerated setting, the risk of that relapse actually could put them at very imminent risk for overdose and death. So that's kind of part then of the assessment as well.

So what I thought I would do, because this, obviously, as I've shown you, isn't necessarily a very straightforward -- kind of you don't look at, you know, a hemoglobin A1c and a glucose level at the moment, but it can get a little more complicated. But I did want to show you kind of an example of at least a typical patient who might meet the criteria for residential care, and I'll point out some of the differences in terms of, you know, what level across the 3.

So adults who are 18 years or older, polysubstance use disorders, including alcohol and benzodiazepines, they actually, because of the associated issues related to their alcohol and benzodiazepine withdrawal, might need medical monitoring at a Level 3.7 that has withdrawal management capability.

Opiate use disorders actually can very effectively be managed in outpatient settings with medications, and so patients who have opiate use disorder alone may actually not need residential levels of care depending on the other dimensions.

Somebody who has no acute medical issues that needs acute hospital care, so pancreatitis, people who need

I&Ds for abscesses or fever in someone with an IVDU who has unexplained. Someone who's not actively suicidal or homicidal but may have had some passive thoughts of suicide in the past or even some attempt. If they're actively suicidal, maybe actually an acute-care hospital may be more appropriate for them.

Someone who's motivated at the moment for treatment or who has -- and has an unstable housing and high relapse potential.

So there are a couple of special populations that I also wanted to just point out. So adolescents, there we may have a lower threshold for residential care because they may need more focus on really sustaining their motivation for treatment that in adolescents can be extremely fleeting, even more so than in adults, and they typically have fewer biomedical issues, so that acute-care inpatient care may not actually be as necessary.

Pregnant women is the second special population that I wanted to point out, and there again we may have lower thresholds for residential care, and the residential care that actually needs accommodations for other children because often they come along with, and they may need more

focus on the medical monitoring because of the pregnancy and so, again, kind of the higher levels within the scope of Level 3.

So my time is up, and my slides are done, so I'm going to turn it over to the next speaker.

* MR. KEATS: Thanks. I'll grab the clicker here. Thank you.

Good morning, everyone. Glad to be here. As Erin said, you were -- my boss, the Chief Medical Officer of Virginia Medicaid, Dr. Neuhausen, was here in March, and Erin said in addition to the focus on residential treatment and the IMD exclusion, there would be some interest since at that point, we were literally a month from launch of our waiver program, which in Virginia, we called the Arts Initiative.

To give you some preliminary results from that initiative, since we're closing in on a year at this point, although because of claims like -- and so on, the results are the first five months.

So I will do a very high-level review of that. There's some more information, I think, in the handout, two-page handout, I think you should have. I'm happy to

answer more questions, but I'll keep it brief.

Also, because of the focus on residential treatment, I've tried to include some additional information in the slides here, so let me just get started.

This is just a slide to try to touch on the point that prior to the implementation of our waiver program this past April, we had very inadequate coverage for substance use disorders for our members. There was no coverage for inpatient detox, for example. Residential treatment was limited solely to pregnant women, and the rates for what treatment services were in the benefit were utterly inadequate. They basically didn't even cover the cost to provide intensive outpatient program treatment, residential treatment, and so on. So this was really a sea change.

ARTS benefit really focused on six primary objectives to expand short-term substance use disorder inpatient detox -- or really "withdrawal management" is the current term -- to all our members to expand short-term residential treatment to all our members to increase the rates for the existing services. In some cases, those rates were quadrupled to make them competitive, and in some instances, they're now actually higher than commercial

rates. We realized we had to sweeten the pot to attract the provider community and expand the services.

We added peer support services for individuals with both substance use disorder and/or mental health conditions. We required all our managed care organizations. There are six that manage this benefit to have a full-time care coordinator whose sole focus would be on these services, and we organized a wide range of training services both to try to improve the number of waivered practitioners as well as additional supports and so on. We did that in close cooperation with our Department of Health.

As Dr. Olsen was saying, we were required, but we also very much a believer, in building this benefit on an ASAM chassis and to ensure that there's a true continuum of care since, as you pointed out, people with substance disorder in their recovery gets two steps forward, one step back, and there has to be a continuum of services.

We also ensured that this benefit was part of the benefits that our managed care organizations manage to ensure that there was integration with the medical side, since there's so much overlap in this population with

medical issues.

I probably don't for this audience need to say a whole lot about the terms of the waiver. Obviously, we went from having the IMD exclusion to having it waived. This wasn't a waiver just to waive that exclusion. It was a broader substance use disorder waiver, but that was a component and a very significant change, as you'll see in a minute.

It also required, as all these waivers do, an impact of the evaluation -- or valuation of the impact of the waiver, which I'll give a couple of highlights on in a moment.

This is a slide just to try to encompass the change in our provider network for our members. Once again, we didn't expand membership. All that's an active discussion in Virginia right now, but we did expand access to services for our existing members, and in the case of residential treatment, all the levels that Dr. Olsen pointed out rolled up together, there was an 18-fold increase. We really went from having essentially no residential treatment providers to having 78 currently.

This just sort of graphically shows the access

that our members had to residential treatment services, orange in this case, and the variation in intensity is lack of access. And the bluer the counties, the better the access. So you can see we really had a much improved -- still parts of the state, and unfortunately, the far southwest, which is sort of the epicenter of the opioid use disorder epidemic in Virginia is still an area where there are gaps.

Once again, just some very high level -- and this reflects the first five months of the program compared to the same five months in 2016. Overall, our members with a substance use disorder, their access to services has increased by 40 percent. The number of members using an opioid use disorder service increased by 49 percent, and spending went up predictably.

However -- and this is very preliminary, so we'll have to see if this holds -- it's been offset by decrease in ED utilization. So far, it looks like a wash, but I just want to caution that the Commissioners have had some very preliminary information.

Regarding the use of the ED, ED visits declined significantly in the first five months for all substance

use disorder-related visits by 31 percent. I'm coming up to a cautionary note at the end.

For opioid disuse disorders, the visits decreased by 39 percent and alcohol use disorder-related visits by 36 percent. However, overall ED utilization decreased by 24 percent for which we currently don't have an explanation. There were no Virginia-wide initiatives that would account for that drop. We're concerned there may be data issues, which we're actively investigating.

We do make note of the fact that substance use disorder-related visits and opioid use disorder in particular decreased at a greater rate or to a greater extent than overall ED visits, which we think is probably a real effect, but our investigators are still digging into this.

And that's my presentation. Thank you.

* DR. OLIVARES: Good morning. I'm Dr. Enrique Olivares. I am an addiction psychiatrist. I apologize for being a little late. The parking attendant at the place where I was supposed to park decided that that wasn't the place even though it was on my printout. So I got a little upset, but then I came here. Another gentleman helped me

out, and I could make it, so thanks to everyone.

I'm coming here to represent Dr. Steve Bentsen, who couldn't make it. He had another commitment, so he sends his apologies. He is one of our Chief Medical Officers.

I am an addiction psychiatrist, as I said, and Director of Addiction Services for Beacon Health Options in Maryland. So I'm going to be talking briefly about the experience in Maryland and touch on some other markets.

Beacon is a large company. We are in about 17 states, and we have about 50 million covered lives in between Medicaid, federal contracts, commercial contracts, et cetera.

We have a lot of experience with mental health and now developing more experience in substance abuse.

In Maryland, we had the contract with the state for about three years now. I came to Beacon three years ago after seven years at University of Maryland as an inpatient psychiatrist. So my experience was seeing the same patients coming in and out of the unit every month with the same set of problems.

We would stabilize them. A lot of them had

comorbid psychiatric conditions, anxiety disorders, mood disorders, schizophrenia, bipolar disorder.

So they would come to the unit, would stay anywhere from three to six days, would be stabilized, sent to a group home or transitional home where most of the time the medications were not filled. They had substance use disorders. No medications were offered for medication-assistive treatment, so there was a sense of uncoordinated care.

And then I came to Beacon, joining a team of other physicians who were intended in changing the situation. So three years ago, we took the mental health. In addition to the mental health contract, we took the SUD contract, and initially we took ASAM 4.0, in patient detox, PHP, IOP, and ambulatory detox. And we've been expanding now to other levels of care, including SUD residential.

We did a fair amount of work on the re-bundling of methadone. So initially, methadone providers were paid a single fee, and now they can bill for different services, including counseling, including medical care, et cetera.

So the last one we added was SUD residential care in addition to the laboratory project, which aims to curve

some practices from some lab providers that started building high tox screens, causing an increase in cost from one year to another of about $40 million. So we've been implementing changes to that program as well as looking more at the SUD residential levels of care.

Dr. Olsen mentioned we cover at the present time residential levels of care, 3.3, 3.5, 3.7, and 3.7 withdrawal management. So we have devoted care managers. There's a team of care managers that get telephone consults. So if someone needs immediate detox, then these reviews take place almost immediately or within 24 hours.

For non-urgent levels of care, like 3.5, 3.7, and 3.3, usually it takes about up to 48 hours to review the cases. So there is a printout of medical necessity criteria. When patients meet medical necessity, they are approved. All our care managers are licensed clinicians or licensed professional counselors or social workers. We have a few nurses that review these cases, in particular, the cases that have to do with withdrawal management. So they review vital signs. They review whether the patient is medically stable for treatment.

So we've been running this program for about six

months now, so we have more experience with the facilities and the providers.

Before we came into the scene, the culture was let's keep it for six months. So the six months was like a magic number, and there's no evidence that six months worked any better than a year or two or whatever number months a time, so there was a struggle with providers saying we drive our systems of care according to medical necessity.

So someone might need to be there for six months, but someone might need to be there only for a month or two until they address their own issues.

The other significant issues that we face is that there is no housing for patients or individuals with mental illness, and sometimes we have comorbidities with substance abuse.

When I was running the inpatient unit, up to 75 percent of patients readmitted within 30 days had comorbidities with alcohol or drugs, and financially hospitals are penalized if they have high rates of readmission within 30 days. So the hospital gets very concerned. We had about 75 percent of those patients

coming to the unit every month.

So there's no housing for individuals with mental illness, and there's a number of patients that get admitted to substance use disorder residential treatment facilities that after a month are doing a lot better from the SUD point of view. However, from the psychiatric point of view, they have significant histories of trauma, significant histories of post-traumatic stress.

In Baltimore, most patients experience violence on the streets. They have seen someone be shot. They have seen someone die in front of them. So the elements of trauma are significant among the population of patients and residential settings, so those issues remain after a month or two. So the temptation is to continue treating these patients for these conditions after they have met criteria for stability from the SUD point of view.

So that has been a challenge, and we've been working on that. We've been working with facilities. We've been going out with meeting -- we're meeting with providers. We are educating them on ASAM criteria. We are conducting webinars. Myself with providers, we've been going out to remote areas in the state. There is another

initiative to promote medication-assistive treatment with Dr. Olsen, who has been leading that effort at the state level, OTP quality groups, medication-assistive treatment, promotion. Beacon has been going out to rural communities to promote more knowledge on residential levels of care.

It's been an ongoing effort. We are going to be developing reports on what works and what doesn't, and we're going to be looking at rates of impatient admission, rates of overdoses, significant events, rates of medical conditions, we are encouraging providers to coordinate care with mental health providers and medical providers, and we are conducting rounds every month with each one of the MCOs. We have eight in the of Maryland, so we coordinate care. We get releases, so we talk from the point of view of comorbidities about medical problems, substance use problems, et cetera.

Finally, in the last minute and a half I have, I'm talking about the experience with the company in other markets. One of the significant challenges -- and yesterday I got an e-mail from the medical director in New Jersey, legislation limiting utilization management for substance use disorder, so sometimes they face mandates to

have patients entering residential treatment for a certain amount of time, three months, six months, whatever, without the insurance company even touching those cases. So from the point of view of utilization management, that poses a challenge.

Also, sometimes we wish there was better communication with the legal system. Sometimes patients are referred to SUD facilities for a certain amount of time. So let's say they're in drug court -- and "Sir, you have to be there for six months," and maybe they don't need to. So we're also encouraging providers to establish better communication with the legal system.

Finally, out-of-network facilities that offer residential treatment in other locations is something we have been looking into.

And I've run out of time, but it's in the press, and you can read about it. I thank you so much.

CHAIR THOMPSON: Thank you very much.

Well, a very meaty topic and very helpful presentations. Thank you all very much.

Let me open it up to the Commissioners to see who would like to kick us off.

Chuck.

COMMISSIONER MILLIGAN: Thank you all very much. Dr. Olsen, it's great to see you again.

I have two or three questions, and, Dr. Olsen, maybe I can start with you. In our discussions previously, we've agreed that IMD is part of a continuum. I guess two, I think, questions related to that. If Medicaid doesn't finance IMDs, is there a gap in the continuum. So just a really -- I assume the answer is yes, that it's your view that it ought to be part of the continuum, but I wanted just to confirm that. So, and then I have a follow-up on that question.

DR. OLSEN: I do. The answer, I think, would be yes. I mean, we certainly have seen, just experientially in Maryland, over the past five months, that the IMD has been really kind of essentially in place, that more people are accessing those services. I think that it's a qualified guess, partly because I do also think that there still is a fair amount of both -- and Dr. Olivares mentioned this -- both in the legal system as well as kind of from other family members and other arenas, where sometimes the push really is for residential care when

there are actually other appropriate alternatives that really may be just as effective and, in some cases, actually more effective, and specifically being kind of intensive outpatient programs and levels of care with medications. And the quality is kind of the other piece that I think, at some point, we're going to have to really get to.

CHAIR THOMPSON: Can I interject to follow up on exactly that point, before you continue on, Chuck, which is, do we have to guard against the perception that residential equals more important, more effective? If your problem is really serious that's where you go versus someplace else. When you say where is the push coming from, where sometimes people might be looking towards that as the treatment setting versus others, can you just say a little bit more about what's driving -- who's being driven and what's driving to that point?

DR. OLSEN: Sure. So I think that there's -- and particularly kind of from the legal end -- that there is a sense that, you know, when somebody kind of goes away they get removed from their environment, that they get kind of very intensive, 24-hour whatever, that somehow that

actually has more robust effectiveness, and that, to some extent, that when they then actually come back to their environment, that somehow now they should actually kind of -- everything should be fixed. And it is a little bit of the realm of kind of, okay, so maybe there really is kind of a cure, and we know that this is a chronic brain disease and for which there is no cure.

And I think then people, both from the legal system, it's much easier to actually have control or kind of feel like they have a sense of control when somebody is actually in a 24-hour monitored setting, as opposed to when someone is in an intensive outpatient program but still actually kind of, you know, remaining within, to some extent, kind of their environment.

From the kind of family and other kind of pushes, that I think there's still -- there is a little bit of that sense of kind of perhaps more safety that with an structured, monitored, 24-hour, kind of 7-day-a-week structure, without really the -- I think the realization that when you -- the person is going to come back to their environment, and addiction is more than just the environment. And so you can change environments, but

unless you've really kind of dealt with all the other issues that are contributing to that addiction, and really effectively, for an opiate use disorder perspective, really providing effective treatment, and what we know is evidence-based treatment, that when that person goes back to their environment, if you really haven't dealt with kind of the addiction, then that's really kind of for naught. So the relapse is going to happen, the person is -- and then somehow it's deemed a failure of kind of the person or the treatment.

CHAIR THOMPSON: Thank you. All right. Back to you, Chuck. Thank you.

COMMISSIONER MILLIGAN: It begs the question about if a court orders is, whether it's medically necessary, Medicaid should pay for it, which is a whole different deal. And we see it with residential treatment centers and other kinds of settings, to where lots of times courts just want to know where they can be able to find somebody, but it doesn't necessarily equal medical necessity from a Medicaid federal reimbursement point of view.

My follow-up question was, if an IMD should be

part of a clinical continuum, what happens if it's not? And if there is an IMD exclusion, are IMDs still used, but it's other funding sources, or is it more of an alternative facility setting, or the person doesn't get served and a crisis happens. I'm curious, in the absence of Medicaid reimbursing for IMD as a service in a continuum, what happens, typically, with that omission in the continuum?

DR. OLSEN: So I can certainly speak on it from the Maryland experience, and I don't know if others maybe can speak from, you know, kind of Virginia and then perhaps other states. I mean, Maryland certainly has used other funding sources, so some of that comes from the federal block grant, and states obviously can have choices in how they spend that federal block grant but that often kind of becomes another source. Maryland also put in, in addition to the federal block grant dollars, put in state-only dollars for services, particularly kind of the non-Medicaid-reimbursable services that then included the residential services.

And then there also are scholarships and there are places that will kind of, you know, look for other sources of funding. It has -- I think my experience has

been that trying to now get patients into -- appropriately get into residential services has become easier, much easier with the IMD waiver, and there are, certainly, states, I understand, where perhaps their block grant coverage or other funding sources is much more limited, where it is extremely difficult to get access to residential services.

DR. KEATS: Yeah. If I could just make a couple of comments, I think this is my personal opinion, but I had the experience of being a managed behavioral health care medical director, managing the same population for 3 ½ years before I took the current position, so I sort of saw this from both sides and was very involved when I was working for the managed care company and the implementation of the ARTS program.

To me, it's still an open question. I suspect that's part of the interest of the Committee here, what is the appropriate role of residential treatment, because, as Dr. Olivares said, you know, a lot of the drivers have to do with a whole host of other issues which aren't, per se, residential treatment related, housing for this population being a huge piece, both in terms of, you know, accessing

residential treatment and then being able to transition out of residential treatment back into the community. If there were enhanced housing options, where would the role of residential treatment be? I suspect it would be somewhat less. The legal system, the inadequacy of community-based services, all those things push, I think, towards residential treatment and make it harder to know what is the optimal role.

In my experience, the ASAM placement criteria requirements for placement in those residential levels of care is the best we've got, in terms of answering that question of what is the optimal role of residential treatment. And I'm sure as my colleagues know, the descriptions there, and the requirements are pretty rigorous, and there's a strong emphasis in the placement criteria that residential treatment -- and all treatment, but particularly residential treatment -- should be person-focused and not program-focused.

You know, the old idea of a 28-day program is still out there, and even though I think most residential programs won't say that overtly, often the conversations I had as a managed care medical director would be, "Well,

they haven't completed their second step yet." "They haven't done their autobiography." And it was clear that the program was still very much built on a programmatic sequence of things that had to be completed.

In Virginia, we actually have, in our waiver requirements from CMS, a requirement that time spent in residential treatment--actually, I think this was revised. Originally it couldn't be more than an average of 30 days, and that actually was changed. We don't know. We're watching very closely. We don't have the data yet -- I know that was a question the Commissioners had -- in terms of what is our current average length of stay in residential treatment. We will have that, but don't have it currently.

I think the other thing that certainly concerns me, and Dr. Olsen referenced this, there's just a huge range in quality of care, I think more than in other treatment settings. I know there's SAMHSA data from last year, the year before last, of people with opioid use disorders discharged from residential treatment, only 30 percent were on some form of medication-assisted treatment. Anecdotally, in Virginia, we know there are program that

are still abstinence based, and we just deployed, yesterday, a survey, a questionnaire, asking all our residential providers what do they provide, what are their barriers? We know, having access, especially in rural areas, to waivered prescribers can be a huge barrier.

So those are just some additional thoughts I wanted to throw in there.

CHAIR THOMPSON: Okay. We have Fred, Kit, and Gustavo, and then Alan.

COMMISSIONER CERISE: Dr. Keats, you touched on part of my question, and that is just, you've seen the rapid growth of providers since you've instituted some of your programs, the quality and what you are doing to try to monitor that and make sure that the treatment is appropriate. I don't know if you want to expand on it anymore.

But I did want to comment on Dr. Olsen's remarks, and I appreciate your remarks around appropriate setting and really kind of the science behind what's the most appropriate way, because oftentimes in health care we default from a comfort level of -- we default to the highest level of care and then we spend years sort of

backing away from that. And we've built an industry around the highest level of care and then we kind of -- we create the evidence for alternatives and spend a lot of time backing away from that.

And so just the work that -- I can't stress enough the importance of having evidence and data to support what is the appropriate level of care before we -- you know, because there's so much pressure to invest right now, and as we do that, to look at what is the right level of care.

But I'm going to ask you specifically to comment on something you touched on, and that is incarcerated individuals, and, you know, absent those options, residential options, inpatient options, whatever we think we might need, people end up in jail, and then they're not getting treated. And maybe some of you could comment on where the opportunities, either for the acute, because we know bad stuff happens with withdrawal and unrecognized withdrawal in jail, and bad stuff happens, and then, you know, getting started on treatment and transitioning out, and where are our opportunities there.

DR. OLIVARES: Very interesting

remarks. I'm just going to go back to the previous question and then I'm going to go back to, you know, your question in terms of the IMD waiver in the State of Maryland. That pays for two stays of 30 days in a calendar year. It pays for the facility fees. It doesn't pay for the room and board. So facilities do bill for, you know, facility fees and room and board separately, so they get two units per day of stay in a residential setting. So they are given up to 60 units twice a year. After the 30 days, and if patients meet medical necessity criteria, Medicaid pays the whole bill, both facility fees and room and board. So that's what we have in place now.

In terms of incarcerated individuals there are some options. There are some programs using Vivitrol. It's a monthly injection for opiate use disorders. They start in jail. The evidence shows that it takes up to six cycles of medication for this medication to be effective, so any less than six months is not very effective. So they have been, you know, engaging motivated individuals, and remember, these individuals have a certain amount of trauma, so injections -- even though you still say they inject themselves with substances like heroin, but when it

is time for a medical professional to inject them with a substance, the story is different.

But there have been programs there in Maryland that have been engaging these individuals and they have been very successful maintaining individuals in the community on Vivitrol, monthly shots, and that's kind of a good experience.

The other one is we're going to be taking over ASAM level 3.1 in 2019. That's sober homes. So that's an alternative to these more expensive levels of care -- 3.3, 3.5, and 3.7. So hopefully, at that point in time, we will be able to motivate providers to, you know, create more sober homes, pretty much like in Philadelphia. There is a paper out there in which, you know, they had good experiences, you know, promoting sober homes, and promoting the same individuals, you know, to manage their own illness. As you know, the significant issue is not only quality of care, which is certainly an issue. It's also motivation, and motivation to enter treatment.

So most individuals enter in a pre-contemplated state, so they really don't believe they need to be there. So part of the residential package in Maryland asks

providers to engage patients in evidence-based treatments, and we are asking, for example, to provide motivational interviewing, and other, you know, counseling, medication-assisted treatment. As Dr. Keats mentioned, you know, many program don't even think about medication-assisted treatment until it's month two or three, or even psychiatric treatment. And when we go back, there has been a diagnosis of bipolar disorder from day one, or schizoaffective disorder, or anxiety disorder, and those issues haven't been addressed. So we are working on these issues, on an ongoing basis.

DR. OLSEN: If could just add two things. And I think part of the issue is that we have actually kind of created with the focus, in many areas, very specifically on residential treatment. We've kind of forgotten that continuum, and I do think that that has, to some extent, created some bottlenecks, kind of at the residential level. And I appreciate, you know, the comments of my other panelists because I do think that there probably are a number of individuals who are in residential and referred to residential settings now who could be served with other alternatives, such as whether it's level 3.1 and IOP and

then medications, that that's something. And that looking at the quality of care of what's also being provided within the residential settings may actually improve, then, maybe you don't need five cycles. Maybe you need one to kind of stabilize and start on the medication.

So I do think that there are some opportunities to really also, then, look at not just incarcerated settings, hospitals, inpatient hospitals, emergency departments, you know, really kind of across the continuum, of also getting patients started on medications, whether it's Vivitrol or buprenorphine, for example, that really have very solid evidence for their effectiveness in treatment opiate abuse disorder, in particular.

I would also just add that -- so ASAM actually is creating a certification program -- it's in development at the moment -- that actually would take the ASAM criteria and has developed standards for the residential levels of care. They've actually not done 3.3. They've done 3.1, 3.5, and 3.7, that will be coming out, so that those programs, the residential treatment providers -- and this is not in lieu of accreditation but kind of on top of accreditation, so that programs and then payers could

actually really see that this provider is meeting the letter of kind of the ASAM criteria for that particular level of care. And so I think it will give some more confidence for payers, for policymakers, for family members, for others to really kind of say, okay, this is kind of a quality program that actually is doing what it says it does.

DR. KEATS: I just wanted to say, to follow up on -- sorry, you had a question about the quality and monitoring the quality, and I just wanted to add to that. I think it was a condition of our waiver. We actually utilized an external company, Westat, to provide just exactly that function, probably not as robust as ASAM will, but taking the ASAM requirements for the levels of care and actually going onsite to the provider programs to make sure they had at least the basics of sort of more of a floor than a ceiling.

But in terms of monitoring the quality care and residential treatment, I mean, there are obviously broad-based quality of metrics, such as initiation and engagement, the NCQA HEDIS measures, some NQF measures that were required to report on. We will begin to report on the

percent of discharges from residential on MAT, for opioid use disorders, since I really think that is the standard of care. And that will -- our long-range plan is to make that part of a value-based payment program.

So we also are working on, and asked our investigators to develop measures so we can see what the current rates are of our members' discharge from residential programs with opioid use disorder, on MAT, since I think it is such a critical angle.

Thanks. Sorry. I think I interrupted somebody.

CHAIR THOMPSON: No. Absolutely. Good. Thank you.

We are coming close to the end of our originally scheduled time. I'm hopeful the panelists could stay with us for about another five minutes so we can finish out our questioning. So Kit and then Gustavo, and Alan will finish us off.

COMMISSIONER GORTON: So, Dr. Olsen, I just want to follow up on the ASAM continuum. At our previous panel -- and at this one we heard a lot about new stuff being built, exciting days, heady stuff. But everything seems to be very much in demonstration stages, and I guess I'm

wondering: Does this continuum exist anywhere? Is it functional anywhere? Is there any place where it has a level of maturity and, dare I ask, data that can allow us to -- I mean, it's a great hypothesis. I like the framework. It's a great way to conceive of it all. But we're making a huge bet on this, and there are bunches of people who are building whole businesses on various elements of this, and particularly in the IMD exclusion. So now we're opening a whole new segment of the delivery system up to federal funding, which, as people know, I have been resistant to in the past. But that ship has sailed, so we move on.

So I guess my question for you or for your colleagues is: Is hope our strategy here? Or do we really know that when we string this all together that we can point to some body of evidence that says, oh, yeah, when you have all the pieces and they operate right and the criteria are right, you get better outcomes for patients and families and you get more cost-effective care for Medicaid or whoever the payer is?

CHAIR THOMPSON: I thought that when you were opening up your question, Kit, you were going to reference

back to some of these earlier discussions that we had where you expressed, as did some other Commissioners, some concern that lifting the IMD exclusion would provide sort of an -- a little bit to the conversation that we're having kind of a drive to that as the solution and the setting as opposed to this continuum, which sounds like it's something we continue to need to guard against.

DR. OLSEN: So I can tell you that there are places across the country where -- and some states, in Rhode Island, for example, and I don't know that they've actually -- it may be still in peer review, but Rhode Island has really taken a strategy of expanding access to medication-assisted therapies across the state. So in correctional settings, in hospitals, they actually have established a set of hospital standards for all of their hospitals, in residential treatment settings, in outpatient settings, and they actually have now -- this paper that's going to be coming out has shown a reduction in overdose mortality kind of a statewide population level. So I would perhaps suggest that, you know, maybe having a presentation from Rhode Island, that might be kind of one point of interest.

The other area is Los Angeles County actually has just adopted the ASAM continuum into all of their systems so that they are going to really be using kind of the ASAM continuum and gathering data from across their county, and their county is larger than many states in terms of population. So that's going to be kind of an area that also will generate data.

And the ASAM criteria kind of through some of its work has published and has been gathering data kind of on the effectiveness of using the ASAM criteria kind of across various different settings. I don't have those kind of numbers off the top of my head, but it's certainly something we can get you. And there are -- David Gastfriend, for example, who has been part of developing the ASAM criteria, who's really been leading on the data side, kind of the evaluations of kind of the implementation of ASAM criteria.

CHAIR THOMPSON: Okay. Gustavo.

COMMISSIONER CRUZ: Thanks. I just have a question. What happens to the patient that has an acute medical condition, say pancreatitis or chronic liver disease, and the hospital gives minimal, if any, substance

abuse treatment? If that patient is able to and is a candidate for residential treatment, is that chronic condition or acute condition an excluding factor after he or she leaves the hospital for residential care?

DR. OLIVARES: I am -- I'm sorry.

DR. OLSEN: I was going to say it shouldn't be.

DR. OLIVARES: It shouldn't be, yeah. I'm in agreement. And I spent many years in hospitals to know that that's -- you know, most of the time that's, you know, a condition that would prevent patients from being referred to a residential setting, inasmuch as patients have, you know, have severe medical problems and sometimes have psychiatric co-morbidities cannot be referred to nursing homes or some other long-term facilities. So that's something that we're working on with the MCOs, so that's where we have these monthly rounds so we can -- we have a care manager that, you know, gets releases to discuss these issues with our colleagues at the MCOs, so there is, you know, coordinated care. And when someone needs, for example, follow-up for HIV, hepatitis B, hepatitis C, endocarditis, the most common conditions among the patients we treat, that there is going to be a medical provider

who's aware of the mental health issues. Also, the State of Maryland has implemented the mandatory enrollment in PDMP, so, you know, the issue is encourage physicians who are prescribing controlled substances to check the PDMP just to make sure that their patients are not accessing medications from other providers, and that's been very effective, and we've seen a decreased rate of co-morbid prescriptions for like opiates and benzodiazepines, which could be fatal in overdose.

CHAIR THOMPSON: Alan.

DR. KEATS: Just one other quick response to -- sorry, I don't know your name. You asked the very appropriate question about, you know, by opening up, expanding access, particularly to this level of care, what's the bang for the buck? I think the overall continuum question is obviously built into our waiver requirements, and I do think we will be able to know in the space of another year or two whether we made a difference and whether it was cost-effective. Teasing out that component from the overall continuum, you've got me thinking it's going to be tougher to sort of narrow it down to that part of the signal. So I guess my response is it

is a work in progress still, and I think putting safeguards in in terms of managed care -- and all our managed care companies are capitated, so obviously they're incented to control costs. The overall has to be cost-neutral. There are safeguards in there. But in terms of what the actual utility and value is, I think we do need to work on better ways to tease it out.

COMMISSIONER WEIL: The origins of the IMD exclusion come from an era when the institutes excluded were largely state mental health institutes, large public facilities, and the federal government didn't want to just pay for what had been a state responsibility.

When I look at the -- I'm trying to understand the relationship between the clear need for residential treatment and the exclusion itself. So, for example, when I look at the Virginia data, I see this massive explosion of residential treatment providers, and I just wonder if you and others in other settings could just give me a little bit of understanding of who these are, size, ownership, pair mix, because not all residential treatment centers would be excluded by the IMD exclusion.

DR. KEATS: Right, and I can't give you an exact

breakout, but --

COMMISSIONER WEIL: In a general sense would be helpful.

DR. KEATS: The majority of the expansion is more traditional residential treatment greater than 16 beds. Some are, you know, private, part of larger national companies. Some are private, not-for-profit. The actual number in there of less than 16 beds -- because there are residential programs in Virginia that are less than 16 beds -- is a minority of that expansion. I don't know off the top of my head to what extent, but most of it's more in the range of sort of more traditional 30-, 40-, 50-bed residential treatment centers.

Just one other quick comment. We only have, I think, four or five 3.1 level, the sober living environment, and I think it's a tremendously underutilized level of care because you're both in the community and you can access partial programs, IOPs, so you can get robust treatment and yet be in the community and avoid some of those negative effects of being yanked out of the community that you eventually return to. We probably need to think about better ways to try to, in Virginia, incentivize the

creation of more of those programs. It's not that people are holding out. There are very few. I hope that helps.

CHAIR THOMPSON: Could I follow up on that question to just ask specifically in Virginia -- because you showed us the map as well -- whether or not it was coverage that created the providers or whether the providers were there and then it was a matter of just being able to reimburse them? And what's going on, in your view, that didn't work in the rest of the state, in southeast Virginia where you say there is a particularly significant --

DR. KEATS: Southwest.

CHAIR THOMPSON: Southwest. A particular need.

DR. KEATS: Yeah, with one exception, the vast majority of those increases are bringing existing providers into the fold, in many instances because the payment rates were utterly inadequate for IOPs, for residential, for partial. In one instance, we created a new sort of delivery model called the Preferred OBOT model, which is collocated behavioral health practitioners with waiver physicians plus or prescribers plus care coordination and provided enhanced reimbursement rate. So that didn't

exist. You'll see that at the bottom, I think, of that grid previously. But, by and large, there were existing providers. Especially the opioid treatment programs, the methadone programs, we had I think three or four. And they had a lot of issues. We had to work very closely with them because they were used to billing cash in most instances. We had to bring them along to billing for unbundled services.

There have been some methadone programs which opened up as a result of the ARTS waiver. I'm trying to think of other instances where programs that didn't exist previously. That's true of some IOPs. Intensive outpatient programs were created in response. Some programs that existed were expanded in response. But, by and large, existing programs that were brought in. What was your question about southwest Virginia?

CHAIR THOMPSON: What's happen there? Why did what worked in the rest of the state not work there? It sounds like that maybe, given your answer, they simply did not have some of the underlying providers present --

DR. KEATS: Yes, that is exactly it.

CHAIR THOMPSON: So the waiver didn't necessarily

change that, at least as of this date.

DR. KEATS: That is correct. We have some -- actually one national company that runs methadone programs has opened a program in that part of the state. Some of our FQHCs have stood up, OBOTs, we have had a number of these OBOT programs created in southwest Virginia. But your comment about programs didn't exist so there was nothing to bring into the fold is true.

CHAIR THOMPSON: Okay. This has been extremely helpful. We kept you ten minutes past your scheduled time. We appreciate your staying with us and your patience, and you've given us a lot more to think about. This is obviously a subject of intense interest among the Commission.

As is our custom, we will take a short break now and allow our panelists to go on with the rest of their day. We'll come back and have an opportunity for public comment and then a discussion among the Commissioners about conclusions and ideas on continuing this work going forward. Thank you again to our panelists for joining us. It has been very helpful. And we will take a 10-minute break.

[Recess.]

CHAIR THOMPSON: All right. Let me give the one-minute warning here before we'll pick up again so conversations can come to an end and we can get back into our seats.

[Pause.]

CHAIR THOMPSON: Okay. We are going to have a short session here before lunch where we have a little bit of a conversation amongst the Commissioners.

I think, though, it could be helpful if there are any public comments, for us to hear them now on any of this morning's proceedings before we move into our Commissioner conversation. So I just want to pause and see if there's any public comments that anybody would like to be making.

PUBLIC COMMENT

0 [No response.]

ADDITIONAL DISCUSSION OF EXAMINING RESIDENTIAL SUBSTANCE USE DISORDER TREATMENT AND THE IMD EXCLUSION

* CHAIR THOMPSON: Okay. Hearing none, we'll move on.

So let's talk a little bit about what we just

heard in the context of some of our prior conversations and what kinds of directions we might like to instruct the staff to continue on with this work. I thought that panel was fantastic. Again, no surprise, given the experiences of the individuals who were coming to share their perspectives.

I was struck by a couple of different things. One is that I do think the points that both Kit, Chuck, and Alan made about the connection of the IMD exclusion to this issue of who are residential providers, what are they doing, how do they fit within the context of care is a really important piece of the conversation from our standpoint.

Martha made the point at an earlier meeting about the number of your clients that you see who would reject residential treatment because of the fact that they're trying to maintain employment, as an example. I think that came out in the panel as well.

Fred made a point about incarceration. I think these issues around when residential treatment becomes viable, what situations complicate their ability, even if they are a good candidate for residential treatment, to be

able to take advantage of that because of some of these other obligations in their lives or because of these other disruptions that can occur.

And some of the issues around the continuum that we heard about seem very problematic in managing some of those transitions. If someone goes into residential treatment but without a plan for how they are maintaining employment when they come out or how they are maintaining treatment when they come out or even, surprisingly to me, how much question there is about what kinds of treatment is actually being delivered in that residential setting, so it seems like we have a lot of questions and a lot of need for additional guidelines and evidence to be built before we really understand how to take advantage of this continuum of care.

In the meantime, we have an epidemic and a crisis and a lot of money potentially being put on the table to help address it.

So let me just offer that up for a beginning part of our conversation.

Martha.

COMMISSIONER CARTER: I think that's a good

setup. Thank you.

I feel compelled to point out the fact that community health centers are a major part of a continuum of care in many communities, and the community health center funding did not get reauthorized with the Continuing Resolution, which puts -- you know, we have to assume that it's going to get refunded, but it also makes business decisions, hiring decisions very difficult.

In my organization, we have the capacity to expand our outpatient MAT program, but I'm really fearful of entering into provider contracts until I know for sure that I have funding.

So I think it's a serious issue. Ninety percent of the patients in our outpatient MAT program are covered by Medicaid, and we have about 200 people in the program now and have capacity to double that. So it really is putting a damper on our ability to respond to the crisis.

CHAIR THOMPSON: Thank you for those comments.

So, Chuck, let me put you on the spot a little bit. We had talked a little bit about the idea of doing a chapter in the June report on continuing from the work that we did last year and sort of setting the stage a little

bit of how foundational chapter in last year's report, this year may be sharpening the focus on a few different issues. And I think that one of the questions that we had asked ourselves was whether or not we wanted to focus particularly on what it meant to have some relief from the IMD exclusion.

I think there's a fair amount of information now that we have -- and maybe, Erin, you can even jump in and comment on this -- in terms of understanding how states are using some of those flexibilities that they've been granted through the 1115 waivers, and what issues still remain for them in terms of actually effectively addressing this crisis? And so that may be the shape of a chapter for the June report. I wanted to invite your thoughts, as well as any others, on kind of that approach.

COMMISSIONER MILLIGAN: I think a June chapter would be a good contribution. I think it would be important for MACPAC to weigh in on the topic because CMS issued new guidance in November around IMD waivers and criteria for waivers. It seems to be an attempt by CMS to invite states to pursue adding IMDs to the continuum, subject to certain requirements around those waivers. So I

continue to think it's important.

I think we do need to be clear to reflect that it's part of a continuum. It's not -- and I take seriously Fred's comment. There is sometimes a tendency to overbuild in brick and mortar, and from a patient safety point of view, think that going to the highest level of care is the most prudent and cautious. So I think that we have to be mindful of that.

I think we have to be mindful of Alan's comment too that the reason IMD exclusion exists historically is that state psych hospitals, more on the mental health side than on the SUD side -- state psych hospitals have been doing that with state and local funding, and the federal government was not interested in just having federal funds displace state funds, but no extra services rendered.

So I think some of the context matters, but I do think that we should weigh in. I think that it belongs as part of a continuum of care, and I think then it really becomes how to use evidence and data to make sure that it doesn't displace appropriate outpatient sites like community health centers.

CHAIR THOMPSON: And that it has a chance of

creating success in its objectives by virtue of the use of clinical guidelines, the after-care arrangements that will help somebody continue to be successful after leaving the program.

COMMISSIONER MILLIGAN: Right. I mean, it has to be a clinically driven part of a treatment plan.

CHAIR THOMPSON: Right.

COMMISSIONER MILLIGAN: It can't simply be residential services. It can't be housing by another name, and so there has to be quality of care. It has to be a clinical model and all that that entails.

CHAIR THOMPSON: Kit, then Brian, then Alan.

COMMISSIONER GORTON: So I don't disagree with any of that.

I do think, though, that the Commission should sound a couple of notes of caution, the first being it's a great framework. It's got these really cool numbers, all of which wraps around it this air of precision and knowledge which doesn't exist.

And so I think we have to be open with the people who read our stuff to say it's a crisis. We need to do something. this seems to be a reasonably good hypothesis

and way to start, and we certainly -- and we don't object to it, but what these are, once again, is a massive series of demonstrations with Medicaid dollars, which may or may not produce -- which won't produce 100 percent good outcomes but may produce predominantly good outcomes, and we sure hope so.

I think the other thing that's interesting to me was, in answer to your question, to the folks in Virginia, is this creating new providers? No. These people were in business before. Well, how were they being paid before? Right now, we're paying them with Medicaid dollars, and so interesting how quickly they shifted their payer mix in order to open up and be willing -- and you showed numbers of enrolled providers, but it will be interesting to look and see what numbers they take. Are they going to take --

I have some personal experience running a program in Virginia, and there are lots of providers in Virginia who will say, "My community has 13 percent Medicaid penetration in Fairfax County," or in Wythe County down in southwest, we have 25 percent Medicaid. So we'll take 13 percent of our clients from Medicaid, but that's it. We will take 25 percent.

So I think it will be interesting to watch that evolve now that the federal dollars are in play, but my resistance to removing the IMD exclusion has been philosophical, but as well this idea that if you open up the federal funding tap -- and smart people are going to take advantage of that -- in Massachusetts where we passed a law that says you get 14 days of inpatient detox without utilization management, no questions asked, there was a flurry of certificate of need requests and a flurry of opening of inpatient beds.

This is to Fred's point. And it wasn't that I think we needed all those new inpatient beds because I think what we were missing is the intermediate levels of care and a way to step people down quickly and repatriate them, but the solution was just to open a whole bunch more inpatient substance use beds, and we're going to use federal dollars to pay for that.

I just think a note of caution in what we write -- we should be careful to say the jury is still out.

CHAIR THOMPSON: Brian.

COMMISSIONER BURWELL: So my own personal preference is to pursue the chapter and ongoing work within

the framework of 1115s. We have a Medicaid program with an IMD exclusion in it. We have this 1115 demonstration to waive that exemption, and to achieve a certain policy objective, a number of states have come forward with demonstrations. What did they do? What's the expanded benefit? What's the restrictions? How are they managing that benefit? What's going on? Some of the data that came from Virginia, and there are a number of other states. I just don't think that kind of information gets out there.

And then this new round of 1115s, well, CMS kind of changed its guidance. The first set, you can only do this if you file the ASAM criteria. Then they backed off on that.

The second go-around, what were the considerations that went into that revision? How many states -- I don't know. We'll know how that is. I mean, I'd just like --

CHAIR THOMPSON: The basic information about how 1115 demonstrations are being structured.

COMMISSIONER BURWELL: I would like to follow this what 1115s are supposed to do to lead to an eventual policy change in the mainstream program over time, and

where are we in that process?

CHAIR THOMPSON: I also think that looking more at the evaluation approaches in the 1115s and saying to what extent are they going to answer some of the questions that have been surfaced in, for example, this panel this morning and in prior panels, or is there a need to suggest more comprehensive research on different timelines in order to be able to inform some of the key questions, or do we have hopes that in fact the evaluations are structured in such a way as to be able to provide that important insight, given what we've discussed about the dollars that we are put ting on the table.

I was struck -- you know, we talked before about the continuum of care and how does the residential treatment kind of fit into that and how do you know when someone is right for that approach in that path versus another path. But I was very struck by the conversation about -- even once somebody has entered that treatment setting, the question of what's really being delivered and do we know what's really being delivered and are we confident about what's being delivered actually being clinically robust, taking into consideration all of the

other comorbidities that that person may be presenting with. That was, I thought, a fairly startling part of the conversation as well.

And I'm not sure if the 1115s are really trying to dive into what's happening inside of some of these settings, particularly if they're just residential and not IMD sort of settings. So that might be something for us to look at.

Alan, Marsha, Toby.

COMMISSIONER WEIL: Yeah. We're running out of time at the Q&A, so I didn't make any comments. At the risk of piling on, I will keep these brief.

I'm also very concerned about the supply-driven demand problem here, and we've seen it in lots of health care. And I think we need to be careful. It's been said. I won't say it again.

We've spent decades trying to reserve the notion of nursing home being an entitlement home and community-based care not. I'd had for us to replicate that by sort of under-investing in the community services as part of the continuum, throwing all the resources at the most expensive end, and then spending decades trying to unwind it.

I just want to -- I had similarly, to Brian's point -- these are research demonstration. The continuum sounds good on paper. Who is managing it? What are we really learning from this? I think we're very much at a learning stage, and I'm very comfortable with us working in this area. But a certain degree of humility is important.

We are in an era where because of the scale of the problem, the nature of the problem, the communication from the administration, we want to do this, but we're not really sure yet what this accomplishes. And I think we should sound that note of caution.

CHAIR THOMPSON: Marsha.

VICE CHAIR GOLD: Yeah. I took away one other thing from the panel, and that was the individual nature of the needs and the patient-centered needs.

I'm not sure. I think it would be good if we can put the patient in the continuum of care. We don't just have a bunch of providers we're paying for, but we have a patient that has certain needs, and those patients differ.

We certainly heard the adolescents differed than the adults, and there's different adults. And people have

work issues and all the rest, so I think whatever we can do to put that back into there.

Another issue related to that is the sort of equity of access. I mean, I'd be interested. We got into this a little with the quality of care and how good it is. We all have anecdotes of people who have kids, and maybe we're luckier our friends have more money and they go looking. And it's hard even when you have money and you're willing to pay to find the right services for patients.

And I can just imagine. I'm interested in whether the Medicaid gives you access to the right kind of services that are going to be effective, and in that regard, I definitely want to add myself to the people who are interested in sort of what we can learn across the states from these.

I'm not that familiar with how the evaluations are set up for these, but in the work requirements evaluation, everything is very decentralized. States will do things. Someone may report data. Well, to take data from 50 places or a variety of places and figure out what it says, if it's on different things, about what we're learning about practice guidelines, how to create

continuums of care, is well near impossible without some systematic nature across it and also with some resources devoted to figuring out what happened.

And so, in general, I think when we had the people from CMS here talking about waiver authorities, they weren't sure how they were going to do things, and it sounds like there is some considerable shift in how waivers are being evaluated. And I think we need to really focus on being able to answer fundamental questions because markets are different. And what works in one place is not likely to work in another, but you don't really know that unless you can look across a number of things and try and tease out common themes. And that's a research nightmare, and it's really hard if you don't have consistent data or anyone paid to look into that.

CHAIR THOMPSON: Toby.

COMMISSIONER DOUGLAS: So I just want to echo the importance of having a chapter and focusing not just on the IMD but the continuum.

One thing I do want to just touch on this issue of the supply-driven demand from a couple perspectives, one back to the discussion about the continuum and how

important it is to focus on that.

From the perspective I had in California when we did not have a continuum and we didn't have IMD, you have big program integrity and supply-driven demand from the lack of having organized delivery systems around substance use disorder and ended up having very business-savvy providers really creating a huge supply-driven demand for certain services that led to program integrity to CNN to just a very, very disorganized system.

So a continuum, a well-organized continuum, I think we need to assess in looking at some of the 1115, can get to a system to where you are getting the right supply in the right places and getting individuals at the right level of care based on ASAM. So that's one piece.

But then the other on the supply that maybe is for a future chapter is really just what we're seeing in California as well as across the country. There just aren't enough of the right providers at the right levels of care; for example, intensive outpatient treatment, very few providers. There's very few ability even within the primary care of being able to do bidirectional care.

So what is it using Medicaid payment policy can

we do to drive the care to the right setting, one, to make sure we're getting the right continuum of care to not create -- you know, misalign supply-driven demand as well as to build out a robust substance use delivery system.

CHAIR THOMPSON: Okay, great. that is a terrific discussion.

And, Erin, thank you for your continued work on this.

I think it sounds like we're clear that we want to have a chapter in June. We want to focus somewhat on IMDs and residential care, but only in the context of the continuum and as it relates to the continuum sounding some of the warnings and raising some of the questions that we've been discussing here and also focus on the 1115, where we stand, who has the 1115s, what kinds of efforts are under way, according to the guidance from CMS, and where we stand in terms of evaluation, both in terms of having data and what kinds of data and where that might introduce some gaps and our knowledge that we could potentially be focused on.

I also think that that may help us in addition to some of the other points that Toby has made, among others,

in eliciting ideas for things that we might want to do in terms of promoting some research in some specific areas where we may not see that well covered under the 1115 demonstration authority.

Okay. Let me provide one more time for the public to comment on any of these discussions.

PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: And we'll break for lunch.

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

AFTERNOON SESSION

[1:05 p.m.]

CHAIR THOMPSON: Okay. We're going to go ahead and kick off our afternoon session with another panel on stakeholder experiences with managed long-term services and supports. Thank you, panelists, for joining us. We are looking forward to your presentations and our conversation with you.

I'm going to have Kristal go and introduce our panelists.

STAKEHOLDER EXPERIENCES WITH MANAGED LONG-TERM SERVICES AND SUPPORTS

* MS. VARDAMAN: Good afternoon, Commissioners. At the public meeting this past October, you heard presentations on various state approaches to managed long-term services and supports, or MLTSS. In particular, representatives from Minnesota and Wisconsin discussed their states' successes and challenges in serving individuals in need of long-term services and supports through managed care.

Following those presentations, Commissioners identified several areas of interest for future work.

Those areas included understanding how states are aligning MLTSS with dual-eligible special needs plans and identifying successful elements of program design.

The purpose of today's panel is to further advance the Commission's deliberation on MLTSS by hearing insights from program stakeholders. Thus, today I'm pleased to introduce you to our three distinguished panelists.

First, we will hear from Mr. Dennis Heaphy, a policy analyst at the Disability Policy Consortium in Massachusetts. Mr. Heaphy is a public health advocate with expertise in disability health, social determinants of health, and population health. His primary activities focus on working with policymakers in the development of culturally competent person-centered health care at the federal and state level. He is co-chair of a statewide coalition promoting health care policies that improve access and outcomes for people with disabilities in Massachusetts. He chairs the Massachusetts dual eligible demonstration advisory committee and is vice chair of the state's 1115 waiver implementation advisory committee. Mr. Heaphy also sits on the advisory council for the National

Center for Complex Health and Social Needs.

Our second presenter is Ms. Michelle Bentzien-Purrington, who is the vice president of MLTSS and Medicare-Medicaid plans for Molina Healthcare. Molina currently offers MLTSS plans in ten states, and the company also participates in the Financial Alignment Initiative in six states. Ms. Bentzien-Purrington is responsible for strategic oversight and operational implementation of person-centered programs for special needs populations. Since joining Molina in 2005, she has served as vice president of business implementation and president of Molina Healthcare of Texas. She currently sits on numerous boards, including that of the National MLTSS Health Plan Association and the National Association of States United for Aging and Disabilities MLTSS Institute Advisory Board.

Our final speaker today will be Mr. David J. Totaro, chief government affairs officer at BAYADA Home Health Care, which operates in 22 states, 12 of which have MLTSS. Mr. Totaro advocates for BAYADA clients and caregivers, interacting with legislative and regulatory officials at the state and federal level. He also manages the company's Research, Analytics, and Innovation office

and its Relationship Management office. He is currently chairman of the Partnership for Medicaid Home-Based Care, a D.C.-based alliance of Medicaid home care providers, managed care companies, national and state home care associations, and business affiliates.

Each speaker has prepared a brief presentation, with the majority of the session's time reserved for conversation between Commissioners and panelists. Following that conversation, we'll have a brief recess and then resume the discussion regarding the direction of the Commission's work on MLTSS.

And now I will turn it over to Mr. Heaphy.

* MR. HEAPHY: Thank you. I think there are slides, right? You've got the slides? Okay. And if you don't like what I say, you can blame Kit Gorton.

[Laughter.]

CHAIR THOMPSON: We do that generally whenever anything goes wrong we don't like.

MR. HEAPHY: Oh, good. Okay.

First I'd like to thank everyone for having me here today. As I'm sitting here presenting to you, I'm actually torn between being grateful to talk about managed

long-term supports in this country and then wanting to be actually on Pennsylvania Avenue screaming, "I am a human being. Don't take my rights away. Don't stick me in a nursing home," as they try to completely do away with Medicare and Medicaid. And so I really am sitting here torn by that because it seems that in this room we're talking about one thing, and outside this room there's something very different going on in the country that could dismantle any dreams that we have about a really robust MLTSS system in this country.

Slide 2. Thanks. I say this not only because so much of my day and activities of daily living are out of my control, but so are the decisions that determine the scope and services available to me. As Congress seems now driven to slash Medicaid, SSI, and other safety net programs necessary for the survival of the lowest-income and vulnerable populations in the United States, beyond LTSS I have to ask myself: Don't they care about those cuts and it will lead to increased preventable morbidity and mortality rates among people with disabilities, elders, and other vulnerable populations? Don't they care that, according to a report put out by UNICEF a little over five

years ago, only Romania ranks lowest among United Nations in child poverty? My hope and that hope of people with disabilities is that instead of slashing Medicaid and putting in caps that will increase burdens on states and direct harm to people like myself, Congress will instead look to the best practices taking place in states like Massachusetts, Minnesota, and others who seek solutions to MLTSS that reward innovation and support investment in HCBS.

What has been achieved in Massachusetts and other states like it is not the result of just beneficent policymakers either. Kit can tell you it comes from dogged advocacy and policymakers with ears to hear our concerns and our potential solutions. For some reason, it eludes policymakers that, unlike other populations or protected classes through civil rights laws, access to civil rights for people with disabilities as complex as mine is only possible through direct investment in federal and state government services that enable us to actually live and participate in the community.

My wheelchair is not a piece of medical equipment. It's an extension of my body and my means of

engaging in work, in education, and in the community. My PCAs are my arms and my legs, the difference between me being imprisoned against my will in an institution, forced to lay in bed in diapers all day with chronic skin ulcers and contractures, urinary tract infections, respiratory infections, with frequent trips to the emergency department and hospital, and my having the opportunity to live a life of human dignity.

Next slide. There is a policymaker in Massachusetts with whom I had ongoing robust discussions about the purpose of LTSS, and MLTSS in particular, and HCBS. So loud and intense were some of these discussions that people would leave the room out of fear that chairs might start flying. I am not exaggerating that, and I have never seen a wheelchair fly, but it might have. But both of us as individuals and MassHealth along with the disability community, as well as a collective, seek more than just transactional relationships. We also seek to strive for relationships that value the needs and realities of the others, and that includes budgetary constraints that the government faces.

Slide 4. Last year, this policymaker was

rewarded by the disability community for her role in creating the One Care demonstration. At the award ceremony, she said, "I get it. Everyone wants to be free." And that's what LTSS is about. That's what managed LTSS is about. It is about the opportunity of providing the ability of people like myself to actually be free.

I'm not ignorant to the fact that Massachusetts has a budget far larger than that of other states. But even as the state now faces increasing pressure at the federal level and constraints at the state level, the commitment to relationship remains. I'm grateful to live in Massachusetts because the fact is LTSS is about consumer control, consumer choice, and dignity of risk, as well as the right to live in the community.

After presenting at an event, my Mom, when she was alive, would say, "You make it look too easy. When everyone sees you in your wheelchair and you are all put together, do they know how many hours it takes to actually get up, how long your bowel routine takes, how complex things are?" What my Mom didn't realize was what a privilege it is actually to be able to do those things because of where I live and how LTSS is viewed, and even

how the MLTSS system is being developed also includes these values. I would speak directly to One Care, the duals demonstration in Massachusetts, and the role that Tufts Unify plays in that, and Commonwealth Care Alliance.

One of the ways Massachusetts' commitment to supporting the rights of people with disabilities is providing us an active voice in how services are delivered. As chair of the state's -- this is Slide 7. I'm sorry. Let me go back. In Slide 6, you'll see some of the best practices, what has been invested in, a conflict-free ombudsman program. These are all exciting innovations that can be replicated in other states and don't necessarily cost more money but actually lead to more efficient and effective health care delivery and MLTSS.

Now Slide 7. I have the honor of working with other consumers to provide guidance to the state in shaping MLTSS delivery systems and supporting an independent living philosophy and recovery principles, and that is foundational to what we do. It's an independent living philosophy and recovery principles. And this morning I was on a very long call with the two plans and One Care grappling with how do we improve LTSS provision to people

with disabilities. And so it's myself on the phone, MassHealth on the phone, and representatives of the plans all grappling with the same issues, trying to come up with common solutions.

Next slide, please. Let's see. Turn the page. Sorry. LTSS is far from perfect in the state. The commonwealth, like other states, has a long way to go ensuring that MLTSS reaches its fullest potential and supporting the health and quality of life of people with disabilities and elders. Right now Massachusetts disability advocates and other advocates are grappling with the implementations of the 1115 waiver and large, medically driven hospital-based accountable care organizations, which will have direct control over LTSS dollars. Will these new ACOs have a vision to provide MLTSS in a manner that will optimize person-centered care, person-centered MLTSS?

Next slide. MLTSS cannot reach its full potential without state and federal governments addressing inequities in access in LTSS across this country that lead to institutional racism and barriers to equal rights. I hear the stories of my brothers and sisters with disabilities across the country and their struggles. I

look at the statistics before by the Commonwealth Fund, Kaiser Foundation, AARP, and others. I recount these inequities. I also know firsthand that being limited where I live in this country and having had to turn down jobs in other states because those states don't offer the Medicaid benefit package and the buy-in that Massachusetts offers. I also worry about what's going to happen to me when I turn 65 with what's taking place in the country. Will I be subjected to artificial Medicaid rules that lead to my being trapped in the endless cycle of spend-downs?

Next slide. We as a country need to make a decision about whether investment in people like myself is an investment in the life and the dignity and civil rights or people or whether this is a perpetuation of my identity as a patient who's solely a taker in American society. Is it going to be one that says we want to track Dennis' every movement and that of his personal care attendant through use of utilitarian means like electronic visit verification?

Next page. Slide 11. And even as I'm saying this and closing this out, let's look at this long list of things I put up there in terms of consumer recommendations

for improvement of MLTSS. This is really about my friends and neighbors and fellow advocates and groups like ADAPT who are forced to chain themselves to staircases or block hallways in Congress to protect the most basic human rights and needs from being taken away from us, as they have and continue to threaten today. Any budget legislation should exclude reconciliation instructions and instead include recommendations on ways to strengthen Medicaid benefits needed to support a system of MLTSS that has the potential to improve the quality of life of people with disabilities rather than cause us direct harm.

Giving Molina or other folks, other plans benefit packages that really don't meet the needs of the populations is not going to work. They can't do what they'd like to do if the benefit packages limit them. So as you consider your approach you're taking to Medicaid and LTSS, I ask you just not to consider me or people like me as data points on a spreadsheet but as human beings worthy of investment and opportunity to pursue the same rights and freedoms that we all believe to be inherent. We do not want to return to the days of Willowbrook and the atrocities that occurred there as well as other

institutions throughout the country. We need to look forward, not back.

Thank you.

* MS. BENTZIEN-PURRINGTON: Hello. Michelle Purrington. Thank you so much for having me here today, and thank you, Dennis. I try not to get emotional every time I hear Dennis speak. It's inspiring.

I am from Molina Healthcare, and I want to talk to you today about four things, four slides, a lot of content, though.

I'm going to start out with a national footprint and a little bit about Molina, not as a commercial but really to give you the context and filter from which this information that I'm sharing is coming.

I'm going to talk to you a little bit about the goals and successes that have been accomplished not only in the programs in which Molina participates but those throughout the country.

And then finally I'll talk about a few recommendations that we feel are promising practices to be considered.

So starting with a little bit of context -- I'm a

visual person, so I've given you a map. I know the colors are hard to see, but what it distills down to is this: Molina operates in managed care plans in 14 states and the Commonwealth of Puerto Rico. In ten of those states, the Medicaid programs include managed long-term services and supports, and just to level set and make sure we're all talking with the same acronyms and coming from the same place, managed long-term services and supports are a Medicaid-funded program paid for through state agencies. You are also going to hear me talk a little bit about Medicare, particularly people who are eligible for both Medicare and Medicaid, under both the dual eligible special needs plans, or D-SNPs, and the Medicare-Medicaid plans, or MMPs, which are the financial alignment demonstrations.

Part of the reason that you're going to hear me talk about that is because approximately 66 percent of the people that we serve who use managed long-term services and supports are dually eligible for both Medicare and Medicaid, so it is important.

The other thing that I would like to share with you, of the ten states in which we have managed long-term services and supports, nine of the ten we also operate a D-

SNP, a dual eligible special needs plan, or an MMP program. And, again, the reason for that is because strategically you can have a more holistic approach to at least the Medicaid, Medicare, and social services available to serve those populations.

We serve about 240,000 -- it fluctuates between 239,000 and 245,000 members who are in programs with MLTSS at this time in those ten states. We operate, as of January 1st, a D-SNP that's a FIDE model, which is a fully integrated dual eligible plan.

Molina has over a decade of experience in both the Medicare and Medicaid populations through our D-SNPs as well as over ten years of experience operating state programs with MLTSS. That's new for some of us who have been in the business 30-plus years, but the good news is it has given us a lot of experience from which to draw.

The other thing that I get questions about a lot are, well, isn't that mostly serving -- MLTSS programs mostly serving older people? Well, for Molina the answer is, yes, the majority of those we serve are elderly people. However, approximately 34 percent of the people that we have on MLTSS programs are disabled. And the other things

that's really important is you hear a lot about nursing facility or institutionalizations in facilities versus home and community-based care. Of those people who are dually eligible, approximately 51 percent of them, of the spend for LTSS services for the Molina population is still through nursing facilities. Although nationally more is now spent on home and community-based services, the reality is most state MLTSS programs have moved elderly people into state managed care programs first before physically disabled and intellectually and developmentally disabled populations. And as a result, we have a higher instance of MLTSS spend currently on institutionalization. I'm proud to say you'll hear about how we're changing that.

The converse of that, of our people who have disabilities, physical or intellectual, only 25 percent of those people are institutionalized, and that is a direct result, as Dennis said, of home and community-based services that are made available to those people through Medicaid programs.

The next slide provides information that is actually a result and summarization of a study done by the Centers for Health Care Administration in conjunction with

NASUAD, and they surveyed 19 states, 12 of whom responded, most of whom have the majority of populations in managed long-term services and supports programs. And there are four common goals of all of these programs when you distill them down.

The first is about improving quality and health outcomes and also experience, which is something that is, I think, really important and often not discussed. It's not just about is my A1C level lower. That's not how we should be looking at is this a successful program or not. It's not about health driving someone's life. It's about when we enable them, social determinants of health -- address social determinants of health, rather, that enable people to live life freely.

So one of the important things that has been accomplished relative to health outcomes and member experience, there are two new tools that have become available to ask members or consumers about their experience with their home and community-based services. There's the National Core Indicators Aging and Disability survey, or NCI-AD. It's a very extensive survey that many states invested in and have tested and yielded results

where you're hearing from the consumers or the members, what is their experience with the programs, and particularly, home and community-based services.

There's also CMS's CAHPS, or their consumer survey. There is now an HCBS, or Home and Community-Based CAHPS survey. It's very, very important that we not just look at medical indicators for how these programs are performing and that we have mechanisms and tested tools to get consumer feedback.

The other thing I'd like to touch upon is, so how are we doing? Well, we're not perfect, as Dennis said. But several surveys have been done, and in the California demonstration, financial alignment demonstration, 80 percent or more of the people participating are satisfied with their health plan, and over 92 percent are satisfied with their care coordinator or service coordinator, the person who is helping them navigate the system. Florida, 77.4 percent reported their quality of life has improved. These are real outcomes.

We're also starting to see data coming out about, well, has there been a change in either health outcomes of the members -- are they healthy or are they sustaining the

health level they have?

The second thing is about rebalancing, allowing people to be free in a community-based setting. This is really important. I know my preference would be living -- is to live at home with my family and friends. So what are we doing about that? Well, we have more people living in home and community-based settings today than we did 10 or 15 years ago, as a result of these supports and services.

Rebalancing rates in New Mexico, as of 2015, 85.7 percent of members are living in the community, rather than in institutions. I will tell you that Molina's personal experience, we moved over 10 percent of the people we had in nursing facilities, over the last two years, each year, into community-based settings, where they wanted to live, and there are countless examples of this.

The other thing we need to start looking at, and the demonstrations or MMPs have helped give us a measuring tool for this, is what about staying in the community? If I'm living in the community, are you keeping me there? Molina's experience is 97 to 99 percent of the people that we are helping coordinate care for, who started out living in the community last year, are still living in the

community this year.

The other thing we were talking about is reducing waiver and waitlists and accessing services. So people will ask me, intellectual and developmentally disabled populations are last to be moved into a managed care environment, and they are shocked when I tell them that Molina actually serves over 40,000 individuals in our 14 states who actually have an intellectual or developmental disability but are in regular Medicaid programs. It doesn't mean they're not getting long-term services and support met, but because of caps and thresholds on waiver programs that afford them long-term services and supports, they are in standard Medicaid programs.

And the way that we, as health plans, are dealing with that, we work with our communities and we find programs available to them. But as Dennis mentioned, if we pay out of pocket to fund services that will ultimately improve their health outcomes and enable them to live in the community, we don't get to submit that for consideration in our funding towards how our programs are working. So we're actually under-reporting what we're spending to actually keep that person healthier and in a

community setting.

And then, finally, budget predictability and managing costs. Through risk-based arrangements, or paying a per-member, per-month amount to a health plan, states are afforded budget predictability, and then we have to work with our consumers, or members, as we refer to them, our provider partners, our community-based service partners, and figure out more efficient ways to deliver the care.

So now I'm going to move on to some recommendations. So, enrollment. The way these improvements, and some of the wonderful outcomes that I have referred to, come from time. To move somebody from a nursing facility back into the community on average takes a fast transition of six months. Typically it can take upwards of 18 months. Your average state Medicaid contract is a three- to five-year term for a health plan.

People can move in and out of Medicaid from plan to plan in a lot of states, as they deem appropriate. That challenges some of us. The other thing, for the Medicare-Medicaid dually eligible persons, the fact that even if a state mandates your Medicaid managed care, you have freedom to be in fee for service or with a managed care plan, if

offerings are available. The challenge with that is there is not a good mechanism for members who are in Medicaid fee for service to have their acute data shared with their managed care plan that covers their Medicaid services. So it can be very difficult to effectively and efficiently coordinate care in a holistic manner, or know if you're affecting outcomes.

These are things we should be able to solve today. Transparency -- the data is available. CMS gets the data. Health plans get the data. States get the data. Making data more easily accessible is a huge opportunity for us to find waste in our system and utilize very precious funds in a more effective way.

Having enrollment, that we will call seamless enrollment or seamless conversion, is another opportunity. What I mean by that is I'm a Medicaid member with Molina today, and tomorrow I become Medicare eligible. I would be happy to have you just put me in with Molina's MMP or D-SNP plan. There are mechanisms for states to do that if CMS lifts the current ban on that. There's efficiencies to be gained in that. Obviously, people would have choice to move away from that, but there would be efficiencies

associated with that. There are other enrollment mechanisms that could help us improve our system.

I want to touch briefly on sustainability and administrative simplification. You should be able to say when something is not working and there are mechanisms to do that. They are different if you are on Medicare versus Medicaid. There is a lot of waste in that process. Different eligibility fees. Again, a lot of administrative waste in their opportunities. And through those financial alignment demonstrations we have some key learnings about ways we can incorporate efficiencies to reduce administrative cost.

I talk about rates, and I just want to briefly, and it's not a pitch to pay us more money. It's health plans. I'll give you an example. In one state, personal care services were being handled by one state government agency, and everything else was in Medicaid. And when the program was changed, the health dollars from that one agency was not considered in the funding and equation. So, basically, we moved the responsibility to provide those services to health plans, but the funds couldn't easily be identified or determined, so the funding didn't come over

with it. We have to be very diligent and watchful about those things.

Health and housing is another. Number one barrier to keeping people in the community is lack of affordable, accessible housing. I think there are huge opportunities for HUD, local housing authorities, to more effectively work with health care agencies and health plans. And, most importantly, we've got to involve consumers and members. They are the recipients of services. They have great ideas. They know the barriers. And one of the positives out of this, that should continue, is managed care plans, state agencies, and federal partners all coming together and having collaboratives and working together.

Thank you.

* MR. TOTARO: Good afternoon, everyone, and thank you for having me here today. Thank you, Michelle. It's an honor to represent providers and give you our perspective regarding what we've learned through several managed care transitions. As the ones who are providing the direct care, we are probably the closest to the beneficiary. So I have to thank you for inviting us and

listening to our thoughts about how the process can be improved to benefit LTSS populations and to those providing their care.

In 2017, BAYADA Home Health Care served over 125,000 clients across 22 states, 12 of which were MLTSS states, and we operated in four international markets. We currently employ over 25,000 nurses, home health aides, therapists, social workers, and other home health care professionals.

One thing, though, that has enabled us to grow since 1975, year after year, has been our adherence to our guiding principles, but also our willingness to embrace change. I have to tell you that some of our initial starts with managed care were not positive, but we have recognized the real promise that managed care now shows in being able to manage the care of medically complex and fragile populations, especially the LTSS community.

So how do we get to a more smooth transition? From a provider standpoint, we see implementation success as a three-legged stool. You take one leg away and the entire stool falls. So first we have to ensure the adequacy of reimbursement rates relative to cost. Second,

we must ensure that states have guidelines in place to support providers, so beneficiaries aren't placed at risk. And lastly, we must make sure that the federal government is prioritizing home and community-based services and that its processes do reflect this.

The LTSS population is growing, and providers are more in demand now than ever before. These three legs in this stool will support a strong and healthy provider network, and thus will ensure that supply is following our ever-increasing demand.

It's well-known that Medicaid services comprise about one-half to one-third of the states' budgets each year, and states are looking at ways to control these costs through managed care implementation. Ultimately, though, it's still the state's fiduciary responsibility to protect our beneficiaries and ensure the ongoing viability of these programs.

Through our experiences, the principal way we see states continuing to ensure beneficiaries are protected is to keep the provider network healthy, by setting adequate reimbursement rates and then reviewing these rates regularly to ensure they maintain a sustainability. Data

shows more and more people are being served in the communities every day, because it's cost effective and it's where people want to be.

But it's often overlooked that in order to keep up with this demand, we must maintain a healthy supply of quality providers. Most states' Medicaid reimbursement rates have not been reviewed in decades. Rates are tied directly to providers' ability to recruit and retain a quality workforce, and it's difficult to compete in the current environment in which hospitals and retailers can pay better than home care providers.

BAYADA views a reasonable or adequate rate if it enable the industry to compete for at least half of the available workforce in the state. In many of our states, we are only able to attract less than one-quarter of the workforce. Without adequate rates, home care services will continue to be affected by staffing shortages, particularly in rural and remote areas. If a state lacks a healthy provider network, then an access-to-care threat will exist. To protect its citizens and prevent an access-to-care issue, it's important that states act prior to managed care implementation to set adequate and attainable rates.

Secondly, we recommend that states protect these rates through a rate floor mandate. If no rate floor is set, MCOs are free to cut rates as a first resource to save money, which is what we experienced during New Jersey's managed care implementation in 2014. This put enormous pressure on providers to continue to provide consistent quality care without the necessary financial resources to retain workers and staff cases. Many of our service offices had to resort to cutting staff pay to remain economically viable.

Rate floors improve providers' ability to delivery consistent care, because they remove the constant threat of rate cute, and therefore enable us providers to plan and staff cases more effectively.

Pennsylvania just recently, in their transition, announced a temporary rate floor policy prior to their roll-out, and we accomplished a permanent rate floor in Delaware this past summer.

However, rate floors are only a temporary solution as the cost of doing business continues to change over time. Cost-of-living increases, coupled with the additional cost of providing services in a managed care

environment require that rates be reviewed regularly and adjusted accordingly. Regular state review ensures that rates reflect actual cost.

Adequate rates serve as a vital lifeline to home and community-based services because rates that accurately reflect the cost of care enable providers to compete with other settings and in other industries to recruit and retain workers. Regular reviews and adjustments of these rates will ensure that beneficiaries continue to have access to quality care in their communities.

In addition to adequate reimbursement, active state involvement and stakeholder input are necessary to ensure a stable managed care implementation process. It's essential that states set up uniform guidelines for MCOs so that providers can focus on care delivery, and so vulnerable populations continue to receive uninterrupted care throughout the transition process.

In our various experiences, managed care requires providers to take on new administrative burdens. Because most states do not mandate MCOs to adopt uniform processes, providers are forced to create duplicative administrative processes for each plan. In New Jersey, for example, each

MCO requires different procedures for client assessments, authorizations, and billing. Each has its own timelines and communication preferences. These and other unnecessary burdens force providers to focus on client administration over client care, which places clients at a greater risk of care interruption.

Additionally, New Jersey's aggressive implementation timeline, back in 2014, left little opportunity for stakeholder input. As a result, stakeholders were ill-prepared and beneficiaries were put at risk of delayed and interrupted care.

Second, in our experience, the initial states that implemented managed care took a hands-off approach to developing any guidance for managed care organizations. We believe it's essential that states direct the development of MCO requirements during managed care transition periods, so that providers are supported and can focus on care delivery.

In North Carolina, BAYADA has been playing an active role in the managed care development process, and we are optimistic that the system that this state is creating will free providers from certain administrative processes

so that client care can remain its top priority. North Carolina today is working to develop a centralized credentialing process, and is planning to develop other support systems such as provider education and training, and standardized language for MCOs and provider contracts.

It's important for states not only to set guidelines but to consistently also enforce them. Pennsylvania instituted a payer-readiness review to ensure access to care. The point of the review was to make sure that all providers and MCOs had contracts in place before day one of the implementation period. However, the state only reviewed the letters of intent that providers submitted, and never reviewed finalized contracts. And, in reality, BAYADA and most providers did not have finalized contracts on day one, resulting in a significant confusion.

So we believe with state-mandated, standardized, and consistently enforced MCOs process in place, providers can continue to focus on delivering quality care.

Managed care has shown great promise in its potential to take on the care of medically complex populations. However, without some federal process changes and improvements, MCOs and providers will continue to be

encumbered by outdated federal regulations and practices. First, the federal government must level the playing field to equalize home and community-based services with nursing care. And second, the federal government must begin to collect meaningful data so that everyone has the information necessary so that we can create better programs to deliver better care.

Currently, nursing home care is prioritized over home and community-based services because archaic federal Medicaid policies dictate that nursing home care must be covered under state Medicaid programs, while home and community-based services remain optional. This creates, of course, an institutional bias. This practice, known as presumptive eligibility, allows an individual to receive nursing home care while their full financial eligibility is being determined. If the federal government made home and community-based services mandatory under state Medicaid plans, rather than an optional waiver LTSS individuals would have equal access to home and community-based care, and this would eliminate the need for us to have to address eligibility in 50 different ways, in 50 different states.

Second, we need a universal data collection

system so that everyone has the information necessary to create and deliver better quality care. Currently, one of the major themes with the transition to managed care is the desire for better outcomes at lower cost, through the use of value-based purchasing programs and pay-for-performance models. The challenge, though, that MCOs and providers face together is that we lack uniform data on Medicaid populations, making it next to impossible to create these programs in any meaningful way.

BAYADA and other providers recognize we are in the best position to develop innovative ways to close these care gaps and add real value to our Medicaid programs. So a nationwide database for MLTSS services will enable providers and MCOs to have the information needed so that we can work together to close these gaps, at lower cost to the MCOs and to the state.

So I want to conclude with a couple of recommendations. First, states must set adequate reimbursements rates, enabling providers to remain competitive in their market prior to turning Medicaid management over to managed care companies. Second, that rate should be protected with a rate floor so that

providers can plan more effectively. Third, it's important that states implement regular rate reviews and adjust rates to reflect the actual cost of doing business. The practice that rates are not reviewed or adjusted for decades at a time just must stop. States must set uniform MCO guidelines, enforce those guidelines, encourage stakeholder involvement, and manage a reasonable implementation timeline so that providers are supported, participants are prepared, and the risk of care interruption is minimized.

And last, the federal government must equalize access to home and community-based services, and begin to collect meaningful data so that the states, our MCOs, our providers can all work together to develop better ways to provide care.

Thank you.

CHAIR THOMPSON: Well, thank you. All of three of you gave fantastic presentations and a lot of really great jumping-off points for conversation among the Commissioners, so thank you very much.

I'm going to ask Brian to start it off on the questioning, but before I do, Leanna, I just -- not to put you on the spot, but I saw you nodding your head at various

points along with the panelists as they were talking, so I also wanted to invite you to amplify any points or comment on any of the presentations from the presenters.

COMMISSIONER GEORGE: Well, being the mom of a child that has intellectual developmental disabilities, I appreciate all of your work and being here, and I reiterate, especially on David's comments about pay.

My daughter is in an ICF in North Carolina. The reason why, we live in a rural community, very low population. We could not get the in-home support, even though she had the waiver to get that, and that just really reiterates the idea of setting a great floor and looking at that type of thing is very important.

And I just thank you again, all three of you. I enjoyed listening to all of you.

CHAIR THOMPSON: Thank you, Leanna.

Brian, do you want to kick us off? And then we have Alan and Kit and Peter.

COMMISSIONER BURWELL: Thank you, all three of you, for very excellent presentations. We greatly enjoyed it and learn from the benefit of your experiences.

The way MACPAC does its work on various Medicaid

issues is generally we identify an area that is of interest to us and one in which we want to do additional research or maybe eventually develop some policy recommendations to Congress. So we have a very strong interest in MLTSS, and there are a number of us who actually are involved in these programs in our day jobs.

But coming away from your presentations, I mean, one very obvious conclusion is this is a very big area. There are a lot of different issues that have to be thought about. We've come a long way in terms of moving to managed care models and improving services for people, but we all agree there are a lot of issues that remain that could still be improved.

So I'm going to put all three of you on the spot a little bit. Moving forward, we've been kind of in the process of educating ourselves about this issue over the last year or so. We're now kind of at a point where we'll hone in on more specific things that we either want to do more in-depth research on, specific components of MLTSS, and/or specific policy recommendations that we may want to move forward over the next 6 to 12 months.

So I'd like your thoughts, if you were kind of

us, what specific components of MLTSS programs do you think you'd give the highest priority in terms of further research and policy analysis.

MS. BENTZIEN-PURRINGTON: I'll start. Since such a high percentage of the population served are dually eligible for Medicare and Medicaid, it's a key opportunity, and I think there are evolutionary opportunities to get us there. I mean, ultimately, why should it be bifurcated? And that's going to take a long time because there will be a lot of opinions, and there will be a lot of thoughtfulness that needs to go into a truly integrated program.

But one of the things that we could do is start with extending permanency for both SNPs and the demonstration programs. They're not perfect. They're getting us a lot further along in true integrated, more holistic care. So that would be a primary recommendation.

The second thing is instituting seamless enrollment and allowing and enabling states to do that once again, converting Medicaid managed care recipients to a like plan on their Medicare side as they age in or become qualified for other reasons.

The other thing that is really important is shared savings. As long as we have bifurcated systems, the reality is -- and there's a lot of debate about this -- do home- and community-based services really impact medical costs, and I think there's good research starting to come about to demonstrate the correlation.

The reality is we've got to look at the pot of money as one, and the only mechanism right now for states to realize overall savings are the demonstrations, which is why we're advocating for permanency or at minimum extensions of the demonstration programs. Those, I would say would be the top three from a holistic policy perspective.

COMMISSIONER BURWELL: I just want to expand on that. So seamless conversation is part of kind of enrollment policy, et cetera. One way to approach it would be to look at enrollment policy from a broad perspective in terms of how consumers are educated about their choices of health plans, how they go about the enrollment broker process, issues around plan switching, around lock-in provisions. I mean, is that an area that you think warrants --

MS. BENTZIEN-PURRINGTON: It is. Thank you for raising that, and I am going to give you actually consumer or beneficiary words out of California -- again, did some really extensive research on this.

I don't understand as an individual why my parents who are Medicare eligible and have the right to have someone come sit and educate them and give them information and then make a choice about what they want to do with Medicare coverage, why they should be afforded that opportunity, but somebody who is a Medicaid-Medicare individual, if you're in a financial alignment demonstration, you are precluded from having a broker sit down at a table and talk to you and educate you on the plan or why in Medicaid programs, enrollment brokers do wonderful work in Medicaid programs, but there are so many limitations on how people who are going to receive services are allowed to learn about the programs. Just because you're of a lower income level does not mean you are an ignorant human being, and you should be afforded the opportunity, whether it's through a dually eligible program or a Medicaid program or a Medicare program, to receive information in a way that works best for you.

And then the other thing is just to echo Dave's comments about any kind of federal or state legislation that limits choice of where I'm placed. Presumptive eligibility is a good example. Holistically, we've got to look at enrollment and education of services, and I think that's a huge opportunity.

MR. TOTARO: Well, I have to be thankful that Michelle is sitting next to me. Michelle and I sat on the partnership board together for -- well, Molina was one of the founding members of that board, and the policies that she just reiterated were policies that we as an alliance have embrace. So the MCOs and the providers have come together, and I would support what she mentioned about the dually eligible community.

I also think that presumptive eligibility is something that we should take a look at that could help solve many of the issues that we have throughout the country. I believe only about six states today do equalize home- and community-based services, put it on the same playing field as other skilled settings. And if we were able to do something at a federal level that would mandate that service, I think that that would be a huge help to

reforming the Medicaid program.

MR. HEAPHY: I would say doing away with institutional bias has to be number one. That people have to have the choice from the start, whether to be a community first. There's so many.

Second is alternative payment methodologies, to use alternative payment methodologies, doing the purchasing of things like a power wheelchair. People look at the power wheelchair as a one-off payment rather than investment in someone's long-term ability to stay and live in the community. So developing really strong understanding of how alternative payment methods might work, and with that would be not to focus on short-term return on investment. That there is so much look towards return on investment immediately that it really precludes long-term opportunity to understand savings over time. So those would be two.

In Massachusetts, our context -- we do a lot of work nationally. That stakeholder engagement in a lot of states is not real. You cannot really measure the involvement of stakeholders and the outcomes that are created.

In Massachusetts, as I was saying earlier, you can measure the involvement of the disability community in the policies that are created every step of the way, and Kit can probably speak to this as well, how we would go back and forth with the state and with plans about what would be best for consumers as identified by consumers. And so we've been shaping MLTSS. You're not taking benefit packages and sticking them into an MLTSS system and you're just getting the same old, same old, except within a different context. SO it's more about a state shifting responsibility and saying, "Well, it's not our fault that the costs are rising. We put in MLTSS instead."

So the MLTSS is actually about transforming the delivery system in a way that meets consumer needs and that holds the MLTSS providers accountable to not just cost, but the quality of life of people living in the community because there are times when cost savings are just not going to be realized, whether they're going to be needed for equal investment in medical as well as LTSS services. But in order to understand that, Medicaid is really going to have to transform how it understands what the purpose of LTSS is.

And as I stated earlier, it's about actualizing our rights to live in the community, and anything that limits that right is really an improvement on -- it is really just a statement about my value as a human being.

So as someone in Mississippi who has to live in a nursing home or have care done by a family member -- and I've had that, some of my family members, and it's not the same they can't take on that burden. We see that burden of responsibility just ripping apart so many families.

So I guess those would be three things. I mean, there are so many more I could just rattle off, what does it mean to provide personal care, what does it mean to make sure that the dual eligible demonstration in Massachusetts, that you have two funding streams, and so you're able to do more creative things. What does that mean?

In my estimation, the estimation of both disabilities, is that the decision should reside in the care team or culturally competent care team that understands independent living philosophy in a recovery model and not in some arbitrary prior authorization process that decides, well, what they're offering this person does not meet our specifications, but what's really being

provided is what the person needs through his -- in the community.

And I'll leave it at that for now, but that's what I would say.

CHAIR THOMPSON: Thank you.

So we'll have Alan, Kit, Peter, Marsha, Chuck.

COMMISSIONER WEIL: Mr. Heaphy, your last two points started to go in the direction of my question.

I learned a lot, and I hear a lot about the policy context from your comments. I got a lot of LTSS. I didn't really get much M, and to look at the policy and the relationship between policy and the MLTSS, it would really help me to go way deeper than the presentations in what is it that you're doing and why are we paying for it and what's the value-add of the layer of management. And I don't feel like I got that, and I would really like to hear some thoughts.

MS. BENTZIEN-PURRINGTON: Well, being from the managed care organization, I'll kick off, and then, Dennis, I'm sure you have some firsthand experience and David as well.

So the primary function -- we do a lot of things.

We assess. We go in the home, and we look at what the needs are, and we communicate with the member. But you know what? That's a lot of administrative stuff, and it serves an important purpose.

But truly, it's navigating the system and empowering and being a go-to person, and I'm going to liken it to an example where I have a family member who -- that's not health care related, but who recently was a victim of a violent crime. Health care, I know. I know how to navigate. I am now serving as an advocate for this family member through the court judicial system, and I cannot tell you how much from managed long-term services and supports I have applied to this situation.

So to answer your question, it's about understanding. What happens with LTSS is we separate the body from the mind from your activities of daily living -- bathing, toileting, et cetera. And that is broken, and it creates waste in the system.

So to Dennis' point, I have needs. I need somebody to come in and assist me so I can live independently and freely. Well, my primary care physician, that is not one thing we discussed.

When a member of ours with intellectual or developmental disability is going to a physical health appointment, there are things with one of the members that I did a ride along with that prepare the family and that member to have a more effective physical health encounter and outcome with that physician. That doesn't happen. It gets lost in the shuffle.

Sometimes because people don't have advocates in their life, sometimes because they don't understand how to navigate the system, and so it really is about bridging the gap between social services and the medical model, and that is really what you do. You're a daily advocate for an individual to navigate an extremely complex system and to not let the social needs get lost in medical speak.

You're often a translator. You're often a cultural translator. You're an enabler and empower, and those are the important things that we do.

And I'm going to pause, and, Dennis, what is your perspective?

MR. HEAPHY: Without the MLTSS, you've got a very binary system. You've got the medical providers on one side with no understanding of what the person's needs are

in the community, and then you have the LTSS providers who really don't have the control of understanding or the ability to influence the medical context. And so by bringing the two together, you're able to provide continuity of care across the system.

And I think for me one of the stories that creates this best is I was going down the street one day in downtown Boston, and this guy is approaching me in a wheel -- in a motor -- no. I'm sorry. A man in a wheelchair with three wheels, a person of color, was clearly semi-intoxicated, dually eligible. We were just talking, and he was couch surfing. He was homeless and had been cycled in and out of the criminal justice system.

Within the managed care context that he joined in Massachusetts, he now has housing. He now is in recovery. He now has a wheelchair that meets his needs, and his costs are being controlled because there's someone actually coordinating all his needs, and there's a sense that someone cares about him. There's a care team context, and so that care team context provides a view and understanding of every aspect of that person's life.

Is that managed care going to be able to take

care of everything? Absolutely not, but at the same time, what the managed care does do, it makes sure this person is receiving whole-person care and not just medical on one side, social determinant on another, and LTSS on that third side. They're all integrated -- I should add BH. For some reason, we silo BH as separate from LTSS, and don't realize that or policy-wise don't take recognition that there's such an overlap between BH and LTSS as well as how do you integrate SDOH into that as well.

So I don't know if that's an answer, but really it's a -- and as a consumer, we distrust these folks. We really do. We have absolute distrust for them, but if it's done in a way that's consumer controlled and we're at the table and we're helping to co-design what's taking place, then there is real great opportunity for managed LTSS to work.

And we're seeing it work in Massachusetts with a dual eligible demonstration, and we see the potential now with 1115 waiver. I say that even coming from a meeting two days ago where folks with straight Medicaid are now going to have -- now going to be put into -- they can opt out managed care with the ACOs starting March 1st. There's

such chaos. There's such confusion, the lock-in, what does it mean for their LTSS and what does it mean to be managed. And I am sitting there for two hours answering questions of these folks, playing the role of the state, trying to advocate for people to join these new ACOs saying, "No. The purpose of this is not just to cut care. The purpose is to integrate care, to give you a team to support you in every aspect of your need." So it's your doctor, your social worker, your LTSS coordinator, all of these folks coming together. That's what MLTSS is about, I think.

CHAIR THOMPSON: Thank you. Darin, did you want to jump in on this point that Alan made?

COMMISSIONER GORDON: Yeah, I just want to give you some examples of what we saw, which echoes a little bit of this. But most of the systems prior to MLTSS that we were seeing around the country, and including in ourselves, was incredibly disparate silos. We had different people responsible for different components of the needs for the members we were serving. We had aging for some home and community-based services. Nursing home was managed by a unit within our agency. The health plans had responsibilities for the acute-care services. And as a

result, there was a cycle of dysfunction that was going on, but it was because of the system we set up. One tangible example of that, discharge -- real active, comprehensive discharge planning from hospitals was lacking. The responsibility when a person got discharged from the hospital and went into a nursing home was someone else's responsibility. It wasn't that the plan was saying, "I'm not interested," just, "Am I going to deploy all the capital and new programming in that particular area when I don't know if I can influence it and if it goes somewhere else where I don't have much of an impact?" We saw that change when we put in MLTSS and brought it all together because they started thinking about things differently. The majority of the folks that ended up in nursing homes in Tennessee came to us because of Medicare, discharged from a hospital into a nursing home, and then we later find out they're ours now. And we could have prevented that, and we started to see that with MLTSS.

And the only other thing I'll throw in there was when it was separate like that, the tools that were available to health plans -- this is a little bit to what Dennis was talking about, having sufficient tools to do the

job right and meet the needs of the consumers. They had home health. At one time they had some private duty nursing, and that was being used as a really costly method in lieu of some services that could have been more appropriately addressed if they had home and community-based services benefits as part of their offering. And when we pulled that together, we started to see that. The more appropriate services that were really trying to meet their needs that were being artificially met through services that were probably more than appropriate for another need, but it was the only tools they had.

MR. HEAPHY: If I could just -- just because it's something that's really important. If MLTSS contracts included a requirement that hospitals are required to report back to the MLTSS plan when a person goes to the ED, the emergency department, or when a person's hospitalized, and then in turn that MLTSS contractor has to be part of the discharge planning, oh, my God, you'd see so much savings and increasing quality of life, because there's a gap in continuity of care that takes place between the hospital and the discharge. I think it would be a very easy fix. Maybe I'm simplifying that, but I truly do think

that that's not a heavy lift.

CHAIR THOMPSON: Okay. As is often the case with us, we're running a little bit late in that we have a number of people who still have questions and we're coming up on a few minutes, so let's see if we can move through them. We have Kit, Peter, Marsha, Chuck, Toby.

COMMISSIONER GORTON: So thank you, everybody, for coming, and great presentations. As you probably know, we periodically issue reports and other publications, and one of the things we do with those is educate the nation on various aspects of context. And, Dennis, I want to take the opportunity of having you here, and since you brought it up in your presentation, to talk a little bit about dignity of risk, what that means to a person with a disability, and how that's an important component to take into account when you design programs like this, because I really think that the Commission should include that when we write to this section.

MR. HEAPHY: I'll give you a couple of just personal scenarios. One was I have -- it might not be surprising to some folks who know me that I've discharged myself out of the hospital against medical orders, against

medical advice, and that's because I knew that if I stayed in the hospital, they would have killed me, because I would have been there -- opportunistic infections or the way they were treating me was not the same type of care I would get at home. So dignity of risk would say within MLTSS that someone will work with Dennis to make sure that when Dennis leaves the hospital, that there's going to be the supports at home that support his ability to support his decision, not made in total isolation, I'm not just going to really be in real jeopardy of harm, but to respect the fact that he wants to go home.

Several years ago, I ended up with osteomyelitis and it just happened. As a result, I had to be hospitalized and have surgery. In a traditional system, I would have just been sent to rehab, which would have really resulted in greater sickness, poorer quality of care, not being in my own home. Instead, my plan invested in a better bed for me, a lift for me, an increase in personal care attendant hours. And so I was able to actually be at home, do rehab at home, do all these things at home, really at great savings.

It also means not doing away with risk but risk

mitigation, because a large percentage of this population have behavioral health needs. And we're not going to force everyone to go into recovery, so how do you make sure that you're providing services in a way that support someone's ability to enter into recovery when they're ready, particularly with the opioid epidemic we have right now? How do we make sure that there are actually supports available to that person that someone's monitoring them, helping them, available to them so when they're ready to go to recovery, they can? But also -- and actually it was Tufts. Several years ago, I was at a -- it was on cost sharing -- meeting with some of the members of Tufts health plan in Massachusetts. I asked them -- because we don't pay co-payments, and that's probably shocking to a lot of folks. But we don't pay co-payments for prescriptions or any service within One Care. And I asked the folks, all the folks that we covered, if it was the end of the month and you were going to spend this money on either your insulin for your diabetes or your high blood pressure medication, or alcohol or whatever substance you're using, which one would you buy? They're going to buy the alcohol, they're going to buy -- and so it's actually making sure

that you're mitigating the risk, but supporting the person's dignity to live in the community, just as you would someone -- just because the state is paying for it does not mean the state should be, again, as I said, tracking me with electronic visit verification or saying, "We're not going to give you this unless you do this," because that model just does not work. And investing in low-threshold housing supports, so if we could do some interesting contracting with HUD so that HUD is providing the housing, but the MLTSS providers are in there providing the support to that person within a safe environment, you know, again, to mitigate risk and support that person's ability to live a healthier life.

Does that answer your question adequately?

COMMISSIONER GORTON: Yes. Thank you.

MR. HEAPHY: It just makes such a radical difference. You're not going to -- people will run away from health care if you don't support dignity of risk, run away, avoid it, because it's tough because that is seen as that's police. I would say instead you provide recovery coaches and emergency departments. You provide LTSS coordinators, you provide peer specialists in emergency

departments and hospitals to support some of the ability to have dignity of risk, but also get the things they need.

CHAIR THOMPSON: Thank you. I'm hopeful that the panelists can stay with us for a few more minutes just to finish this round of questions, if that's possible. Peter.

COMMISSIONER SZILAGYI: Yeah, I had two questions, but you guys have already answered the first. First of all, thank you for an excellent presentation. Dennis, your presentation is completely inspiring to me, amazingly inspiring. I was wondering if you could think a little bit about the issue of return on investment, and this piggybacks from Dennis' comment about how the overfocus on return on investment. At the same time, it's really difficult to avoid the concept of return on investment, and part of it is the challenge of we just don't know how to measure it right, particularly in this issue, but also in other areas where we are looking for short-term return on investment, where the investment in health brings return in other areas other than health, and flip side, the investment in social services brings return on health.

So for this area, do you have thoughts, do you

have sort of long-term thoughts about how we should be measuring return on investment and how that might actually help us in terms of the policy decisions to make?

MR. HEAPHY: Do you want to start? I'm dominating this --

CHAIR THOMPSON: I'm going to ask the panelists also to try to be as short in your answers as you can just so we can cover everyone else as well.

MS. BENTZIEN-PURRINGTON: Well, to really even measure return on investment, first of all, go in with baselines, and that should be something from a policy perspective we look at. We often start programs, and we don't have appropriate baselines from which to judge where we came.

Secondly, I would say the data point that I made earlier, the data's all out there, using it more effectively.

And then, third, I think we have to really look at bending the cost curve and accepting that rather than refuting it. So, for example, on average, in the ten states in which we support MLTSS programs, an average nursing facility long-term-care bill is five grand a month.

For most members, even with their medical costs built in, when they come out to the community, it's about $1,200 to $2,000 a month. A huge cost difference. So when I say that we keep 97 to 99 percent of the people in the community year over year, there is a cost avoidance there that people just need to get comfortable with understanding, accepting, and looking at it differently. It's not always savings.

The other thing -- and, Dennis, I'd love you to chime in on this -- is a lot of these folks are not on a trajectory of improvement. This is not I'm hypertensive and I take my high blood pressure medicine and I'm going to, you know, have a good outcome and sustain or actually have an improve. It's not I lower my A1C by taking this pill, or my cholesterol. This is as I have dementia, I am going to progress and I am going to lose the ability of independence over time, and can we slow or change that trajectory? As that trajectory increases, hopefully at a slow rate, my costs may increase for lots of reasons, not just my home costs.

So we have to take these things into consideration when we judge the cost-effectiveness in ROI.

MR. HEAPHY: Just to add to what you said, we can't hold an MLTSS plan accountable for the increased costs of providing care for that person. And I think ROI has to include -- well, first, it's how do you define quality. And so ROI includes the determination of what quality is. And so if quality includes social value and someone's quality of life actually increases, the ability to participate in the community, their opportunity -- and not to force employment but opportunity to actually engage in employment, to have a -- the basic question is: Is there value in having people with disabilities and elders living in the community or children with disabilities living in the community or not? And I think that goes into ROI. We have more children with disabilities living in the community, participating in these activities, than other countries. I think that's -- so it is about what do we invest in and how do we define return on investment. And I'm very realistic and realize, you know, we want to, we need to in order to survive as a country, have some sort of financial return on investment, and it is about bending the cost curve, because -- and any state that's going to look at MLTSS as a quick fix for the financial woes is going

into MLTSS for the wrong reason. They're not going to realize the savings. Their costs are going to go up. ED visits are going to go up. Hospitalizations are going to go up. It's just not going to happen. It's like how do you modulate the costs as they currently are and bend them over time.

CHAIR THOMPSON: Marsha.

VICE CHAIR GOLD: Thank you. We're really lucky to have three people clearly at the top of their game, both in terms of Dennis' knowledge in Massachusetts where you come from, and Molina has been in this for a long time, and you've been all over the place in home health.

One thing I take away from all your presentations is that key to sort of the effectiveness of these programs is knowing and respecting the population that they're serving and then both understanding how to care for them and being in an environment, a regulatory environment, whatever kind of environment where the state, the federal government lets you do what's there. And there's a whole lot packed into that that we don't have time to get into.

One of the questions -- the question I have for you, I think especially for Michelle and Dennis, is -- I

did some work with Kaiser Family Foundation about three years ago looking at some of the states that were going into the financial alignment demonstrations and looking at the health plans there. And these are the ones who went, not the ones who didn't. And we found enormous variability in the prior experience with managed care for this -- in general and for this type of population and across the health plans that were in there. Probably the most experienced ones were the ones like Molina who had some experience with non-dual Medicaid managed care.

And I guess my question is: We sort of talk national policy here, and we have to think of something as it might play out in different states and with different health plans. Has that changed? I mean, what's the sophistication level across the states in dealing with these kind of issues and across the health plan industry?

MS. BENTZIEN-PURRINGTON: So I'm going to speak to the latter first. Across the health plan industry, it's improving and increasing because more and more companies are finding this is an important market sector when you look at it from a business term to be in. And the other thing I'll say is to my colleagues, we are collaborative.

This is not something you fix in a vacuum. None of us are perfect, and it's too important to get wrong. So we've got to focus on working together and getting it right. So the collaboration in the industry I think is really remarkable, and not just amongst health plans but with stakeholders, meaning the consumers that are served, as well as state and federal agencies.

Secondly, relative to the state governments, I will tell you I feel so fortunate to have in the last decade worked with some of the smartest, most dedicated, underpaid individuals at state agencies you could absolutely know in the world. And what makes me sad is the rate of turnover in institutional knowledge that is absolutely critical is rapidly declining. And there is a huge learning curve, and I know the health plans feel it. I know that the consumers feel it. And I believe that our legislators are feeling it, too, as far as having folks that know -- you know, history does repeat itself for the good and the bad, and there are mistakes we are going to continue to make at the state level and at the federal level because of institutional knowledge lost. And I think we have to be very realistic about that.

CHAIR THOMPSON: Chuck, then Toby are going to end us up. I'm sorry. I'm just going to have to move this along in order for us to continue on our agenda. So Chuck passes. Toby.

COMMISSIONER DOUGLAS: I'll try to be brief. My question is for David. Great presentation, and the question I have is: When I think of your presentation, a lot of the elements of success are really around safeguards and protections within a managed care structure. But part of the promise of MLTSS is really bringing, you know, in essence the social care within the health care system, but not medicalizing it. And really, when you think of that and we think of delivery and payment reform, what are the successful elements that are needed within your delivery system to really drive delivery and value-based payment to work across your system with the rest of the health care system?

MR. TOTARO: Well, I think we focused -- at least I focused on in my presentation the need for adequate reimbursement because it directly relates to the quality of the nurses that we can recruit and retain. We know that more than half of our workforce works at some point in time

in their career in fast food. And so if we're going to sustain an industry, which does give back many, many times more than it takes, we do need adequate reimbursement to compensate for the needs that we have.

COMMISSIONER DOUGLAS: I understand that, but that to me just could be the same. I could be in my old hat, and you could come up to me in fee-for-service and say that. So I guess what I'm asking is: What are the elements for you to work with other parts of the system to think differently about how we provide care across the system?

MR. TOTARO: Well, one thing that I think I mentioned at the very beginning of my presentation is that we had some rough starts with managed care, but that we have become believers that it is a system that can have very positive influence on the way we treat the LTSS population. And just recently, we've had many managed care companies reach out to us to develop value-based purchasing and pay-for-performance programs, recognizing that -- you know, establishing reward systems for better outcomes.

However, so far, though, most of those programs are still based on cost control rather than true outcomes.

But if we can get to that point, I think that that's a very positive step forward.

MR. HEAPHY: There's a lot of focus on, in the home health industry, quality measures saying: "Did the person come on time? Did the person leave?" As opposed to asking the consumer, "Did you have a choice over who provided your care within that agency model? Did they do what you requested them to do?" These are the sorts of things that also need to be looked at in terms of defining what value is and to sort of transforming the home health industry model in a way that actually meets the needs of the newer generations of people. And I do think you'll find cost savings in that as well.

MS. BENTZIEN-PURRINGTON: Do we have time for just -- okay, just briefly. I'm just going to be very candid, and I think the reality is our fee-for-service system relative to home-based is based on a per hour rate. It does not incentivize efficiency or effectiveness or the needs of the consumers. If I can get in and out and provide Dennis the services he needs in ten minutes, I am disincentivized by the current system to do so. And there are restrictions for managed care organizations on straying

from that per hour payment model, and I think it's a hard question to address, but I think we really need to look at it. It's a huge opportunity.

The second thing that I would be remiss in not asking you to contemplate from a policy perspective is caregiver training. Much as we're talking about the great home care that BAYADA and other such agencies provide, family caregivers, there are tens of millions of dollars equivalent provided by family caregivers in an unpaid fashion, and the burnout and turnover rate is significant. And if we invest in not only training but respite and some additional opportunities, we could have a different natural support system available in the way of neighbors and friends and trusted family members. And I think we need to really look at that. I'm sorry to continue to bring up California, but there was a grant done and some great work done around investing in caregiver training and how it affects outcomes. And so I think that's another policy opportunity because it addresses not only paid but unpaid caregivers. Thank you.

MR. HEAPHY: And just in this room -- most of the people in this room are white, and to make sure that

whatever is created addresses inequities based on race, ethnicity, has to be a priority, as well as across populations, whether it be behavioral health, developmental disability, acquired disability, or elders, that the focus also needs to include that there be equity across the country in all these different areas, because unless that's addressed, we're going to continue this system of haves and have-nots, which really does a disservice to the folks who have tremendous amounts of unmet need, and as a result of that unmet need are also higher-costing folks in the country. So I think that's got to be part of what you do.

CHAIR THOMPSON: Thank you. Well, this has been a very rich and meaningful conversation. You've given us a lot of things to talk about.

Again, as is our custom, we will now excuse the panelists. We'll take a short break of ten minutes, come back, and there will be an opportunity for public comment and then a Commissioner discussion about our future directions and efforts in this area.

Thank you, panelists. This has been extremely fruitful and productive for us, and we appreciate your making time out of your schedules to spend with us today.

MR. HEAPHY: Thank you.

[Applause.]

[Recess.]

CHAIR THOMPSON: Okay. Why don't we get started again. Just an agenda timing issue. I think we're going to eliminate the next planned break and just power through. That will help us catch up on our time, and I think we'll be fine for everybody, since we just had a break.

CHAIR THOMPSON: So I promised and I would like to invite, before the Commissioners start their discussion about digesting the previous panel and the panel that we had of state officials, in trying to put that together and formulate some ideas about where we focus our time and attention around MLTSS, to invite the public to come up and make any general comments or specific comments in response to the earlier panel or to, in general, with any perspectives on the subject of MLTSS that we should be hearing and consideration.

PUBLIC COMMENT

* MS. DOBSON: I'm back again. Sorry. Camille Dobson, Deputy Executive Director of the National Association of States United for Aging and Disabilities.

We represent state aging and disability directors who delivery HCBS as well as a number of the LTSS directors in the Medicaid agencies who deliver these programs.

There are a couple of things that came up, questions from the Commissioners that I thought I might just address, from a state perspective, since I know you heard from them in October and I said some things back then, but I thought they were relevant.

So to Commissioner Weil's question about, you know, what's the M in MLTSS, and I think the question that the states have in front of them is whether to build a system or to buy a system, right. And they could do all the things that the plans are doing. They could figure out how to integrate their acute care program with their LTSS program and put care teams in place. They just don't have the capacity to do it. They're never going to get the number of employees they need to be able to do it well.

And, frankly, the plans bring a lot of ancillary benefits, like claims processing and member call centers and a quality management program, which is their core business. It's what they do. And so they can bring that additional value to the program that I think the states

just can't replicate. So they're making the decision if they want to get an integrated program that really focuses on the whole person, to buy the expertise, and so I think that's what they're doing. That what at least the states tell us.

Commissioner Gold talked about the plans' and states' experience in dealing with these populations, and I would echo I think what Michelle said. We continue to hear, when we go out and talk to states who are interested in doing MLTSS that plans don't know what they're doing, and that's not honestly true. There are a number of national companies, in particular, who have been doing this for a long time in the duals space, as well in the Medicaid-only space, who have built processes and approaches to serving very challenging and high-need populations effectively.

But the plans will do what the plans do, right? It's really about the state. And so my issue, and our concern is always the expertise at the state level. I cannot say strongly enough the issue of expertise leaving state agencies. You need a particularly hard shell to fight -- to deal with the health plans who want to do

certain -- I'm moderating my tone. See, Penny is laughing. She knows what I want to say. What I won't say is to address the concerns of their health plans, as well as handle the concerns of the consumers and the providers.

More so, honestly, I think, than an acute care program, it really calls for a specific type of expertise that is lacking at the state. They are underpaid, absolutely, and they've got a terribly hard job.

So, really, I think, what I would leave you with is you can design a great program but if you don't have state staff to implement a great program, you'll get the kind of outcomes that none of us want, which is providers not being protected, consumers not being heard and their voices not being heard in the process. They just want to get the system moving. They want to get it done, and what then happens, you have shortcuts, really, that are taken, that are harmful for the whole system.

And we tell the states all the time, if you have one bad implementation, it colors the entire country. And so we have been spending some time, in the last couple of years, fighting some poor implementations that happened in the country, but now we have great examples. For example,

Virginia has completely moved their entire program into MLTSS, effective 1/1/2018. And for those of you that are here in the D.C. area, have you seen any articles in the Washington Post or the Richmond Times Dispatch? You haven't seen any, because they took a really long time.

They did a very collaborative engagement with their providers and their consumers. They did a lot of standardization of approaches with their health plans, credentialing forms, et cetera, to have a successful implementation. Likewise in Pennsylvania, they started in the Pittsburgh area, in January. Now that's only three weeks in, so time will tell, but so far, so good.

So it's really about the execution of the plan and not the design of the plan. So I like to tell states, stop focusing on your RFP. That is the least, really, right now, of your worries, because the plans will come to you at the table and offer all kinds of great things they'll do for you. What you need to worry about is talking to stakeholders, deciding what kind of protections you're going to put in place, the kinds of supports for consumers that you want to put in place, engagement with your providers, who have been there the whole time, with,

frankly, crappy rates, for the most part, in the HCBS space. Those are the things you need to focus on. The plans will come, and then you need to figure out how to turn your staff, who have been doing pain claims, or doing case management, or doing quality oversight into a contract monitoring unit that is really going to be effective in holding the plans accountable.

I think one of the national leaders in this space is Patti Killingsworth from Tennessee. I hope Darin would agree, Commissioner Gordon would agree. And she always says that you need to manage a managed care program, and that's really the key here.

So I would offer to the Commissioners that a lot of the suggestions that the speakers made today, about making it easier to coordinate with Medicare is a huge, huge problem for most states. CMS is making it easier but it still continues to be an issue. But some of the issues that are less regulatory in nature around program management and program design, standardizing and addressing consumer stakeholder issues, I think, are equally ripe for your consideration.

So I'll stop there.

CHAIR THOMPSON: Thank you, Camille. Any other comments?

[No response.]

CONTINUED DISCUSSION OF STAKEHOLDER EXPERIENCES WITH MANAGED LONG-TERM SERVICES AND SUPPORTS

* CHAIR THOMPSON: Okay. Chuck, we cut you off in the last session, or you very nicely gave up your time. So let me ask you to sort of just start us off in this conversation.

COMMISSIONER MILLIGAN: Sure. I'm happy to forego it, but thank you.

I had a few points I wanted to make, I think just in terms of framing for the Commission, where our work or our either descriptive or kind of where we can go. One of the issues is I think in managed care sometimes it also serves as a way of eliminating a waiting list. I know that in our health plan, we do MLTSS in my health plan in New Mexico, we are required to do a health risk assessment for all members. We are required to then do a comprehensive needs assessment for members who have need for LTSS services, and then we are required to deliver that MLTSS services.

So it has effectively eliminated, over the years of this program, any waitlist for what used to be a disabled and elderly, 1915(c)-type waiver. I don't know how representative that is, so I think one of the areas of inquiry that might be fruitful for the Commission staff is to what extent does MLTSS influence waitlist, waitlist policy, getting people into care, that sort of things. So as an access measure.

The second is I wanted to kind of go to the rate conversation for a minute. There is rate pressure on providers. There are increasing costs on HCBS providers. Let me just check off a few. These are the -- this is the list that's pretty common in a lot of markets and a lot of places. Increasingly, jurisdictions are raising minimum wage, which often impacts personal care attendance. There are new costs of doing business for the employers, including the Affordable Care Act and providing health insurance to their attendants who work for them, if that employer is subject to coverage requirements under the ACA. There are increasing costs of doing business around EVV and other administrative requirements. So I think it is accurate to say that there's more cost pressure on

providers.

It is also, I think, accurate to say states are not typically raising fee schedules for personal care services. And so for the managed care organizations, we're kind of caught in the tension between our rates not reflecting the increased cost of doing business from what the state is paying us, where they're kind of level with what they've always paid per hour in a now obsolete state fee schedule, with the actual cost of doing business for the providers.

If Stacey was here I would put this question to her. How do we address, I think, the need to increase rates for personal care services in such a way that there isn't a two- or three-year lag always about how that rate increase reflects in the cap payments, because of when the encounters come into the system and when that leads to pricing and leads to rate-setting. And I think we're always two or three years chasing that. And so I do want to -- I do think there is a legitimate rate issue, I think, at MLTSS, because of the lag with encounters that can be exacerbated, and I think a little work on that would be useful for the Commission.

The third is, I wanted to go to Alan's comment, and others have touched on it, Darin and Camille, and others have touched on the M part of MLTSS. I just, I think, want to make one contribution beyond what folks have already heard. One of the things that we're doing in the health plan where I work is finding alternative -- additional revenue for providers to be part of an integrative team, and I will give a couple of examples.

We actually have in place value-based contracting models that are not cost-based, as David said in his presentation, but rather quality bonus-based, and what we're doing with three of our very large personal care service agency providers is paying them bonuses if they help us address HEDIS measures for the individuals that they're doing attendant care for, because they're in these members' homes many days a week, they have trusted relationships. If the barrier is getting the member into care to get that screening done or to get that testing done for a HEDIS measure, the attendant is somebody who is a trusted component of that plan. And so we're tying off acute care measures, HEDIS measure, with quality bonuses for attendant care workers, and it's proving to be

effective.

And there's another component which is where we've trained a lot of attendants at some of these agencies to be essentially community health workers, and we're also paying them to do health education around disease management programs, whether it's CHF or diabetes or other things. So we're paying for some of their time while they're in the home, additive to their PCS hours, to do health education.

So I just wanted to offer those contributions. I think I will stop there.

CHAIR THOMPSON: Let me just throw in a couple of thoughts and then, Bill, you jump in.

There's so much here for us to consider. I do feel like we have to chunk this up in some fashion, maybe with shorter-term meaning things that we could potentially address, or at least begin to describe in the June chapter, and then things that may be elements of research or development that may lag after the June chapter. So let me just try at a few sort of general subject areas.

So one issue it seems to me that we are hearing a lot about, that we've talked before about, is the dual

eligible issue. I'm not exactly sure what it is we think we might want to be saying about the dual eligible issue. Congress will decide what it's going to do on D-SNPs. You know, there might be some points of coordination or help that we could consider. We face, in that area, what we face in duals in general, which is areas where we want to start to make recommendations about Medicare. So we need to think about how much of our attention should be focused there.

There is the issue of implementation, and I think this is -- some of the things that we heard from the panel had to do with how do you engage stakeholders in the implementation, how do you do design during the course of the implementation, how do you ready yourself for the implementation. And I think there is a fairly good amount of data out there about what has worked, what has made a difference, where there have been stumbles, what that has maybe been about where we could think about correcting that for future implementations.

We've talked about contract monitoring before. That's a subject that I think -- I'm just going to set aside as something that I think will be, you know, a

continuing point of conversation for us, about measuring quality, measuring performance, measuring compliance, how do you think about organizing yourself in order to be able to do that. Those might be -- both the implementation issues and the monitoring issues, maybe to a lesser extent than monitoring issues, might be some things that we could begin to describe or address in terms of experiences, at least, in the June chapter.

There's a set of issues, and, Chuck, you're touching on some of these for me, and I also lament Stacey's absence for this part of the conversation, but it's about some of what we've talked about in terms of how do we acknowledge the degree of services that might -- the kinds and degrees of services that might be delivered in support of a care plan, focused on the person, when those kinds of services may not have traditionally been provided, may not be part of a typical or traditional state benefit plan, may have been underpaid, to the extent that they were delivered earlier, and how do we begin to use encounter data and use payment data and use expectations about performance and outcomes to construct the proper way in which we can recognize those costs?

And then that gets wrapped up, a little bit, in that value-based purchasing conversation, and how do we orient ourselves toward a different way of thinking about rewarding providers for the services that they're delivering and for their participation in the outcomes we're trying to achieve.

So those seem to me to be some different constellations. I don't know if the Commissioners have different points of view or reactions to any of those, in terms of amendments to that kind of framework.

Darin, let me just jump in to you, and then Kit, and then bill.

COMMISSIONER GORDON: It's just going -- I was thinking about what you were saying. I was thinking about a problem that we had run into, and it's along the lines that you were talking about, just making sure that rates capture the true, full experience. But with these programs, as you heard discussed today, you're moving more people into home and community-based services setting. That's part of what results from these programs.

What happens, and, you know, obviously the level of care coordination while a person is at home was actually

higher, and our expectations were higher, and our staffing ratios were higher than if a person was in an institution. But, over time, as you're moving more people to the community, the overall cost of the program is going down, or flatter, the administrative costs you were paying a health plan starts to either stay flat or go down, yet you're moving more people into community that requires more care coordinators for a health plan.

So it gets to this whole thing about just thinking through, as people are thinking those things through, because, ultimately, over time, the thing we were wanting to happen was happening, but the way we were approaching how we did rates, consistent with some of the things that Michelle said, what Chuck had said, what you said, were really, in time, if we didn't address that we're really going to start being counterproductive and start harming the successes that we had.

CHAIR THOMPSON: Kit.

COMMISSIONER GORTON: So my thought is similar to Darin's. I think there's another foundational piece that we need to do maybe in the June report, if it's possible, that sets the stage for that other work, and that's the ROI

independence, you know -- the sort of the general context -- the institutional bias. That's what I'm looking for. If we don't address the aspirations of the consumers, the needs of the consumers to be valued members of society, those sorts of things, then I think doing the longer-term work becomes difficult, because it all comes down to some sort of very boxed-in, measured ROI.

And I think when we start talking about that, and to Darin's point, valuing different things in different ways, right, wanting health plans to hire LTSS coordinators because that's how you get the social care integrated into the rest of the care plan, I think we need a philosophical framework, a grounding, in terms of what are we trying to accomplish in the program.

And I think we've had an incomplete description of what should go into an ROI calculation of what are the things that we get out of an ROI calculation, some of which are intangible and hard to value, but we ought to at least say, but we think Congress and the states and society at large has said these things are of value, and so they need to be taken into account in terms of the analysis.

And so it just seems to me that if we can do a

little bit of descriptive work about those topics in June, then it captures the conversations we've had in October and now, and then gives us something to build on when we do the subsequent analytic work.

CHAIR THOMPSON: I mean, I think that subject is important in terms of describing what it is we're trying to accomplish and all the things that are going to go into creating success in accomplishing that. I see that as a little bit -- I mean, I'm a little worried about calling that ROI, and I'm a little bit worried about calling that institutional bias because I think those are all slightly different things. So maybe we can ask the staff to start thinking about -- I'm assuming, Kit, but test me on this.

Would you agree that what we're trying to do is say what are we trying to accomplish, and can we measure what we're trying to accomplish? What are the challenges in measuring what we're trying to accomplish, and what issues does that create in terms of expectations placed on plans or providers and connecting that with a historic fee-for-service approach?

COMMISSIONER GORTON: Yes. Much more articulate putting it --

VICE CHAIR GOLD: Is it a level playing field that we're talking about and understanding what a level playing field between institutional care and others would –

CHAIR THOMPSON: No. That's exactly what I'm trying not to try to open up that -- I mean, not that we couldn't as a commission decide that we want to address that, but I think that expands what we're asking Kristal to address in the June chapter to such a degree that it might be quite challenging to figure out the beginning or the end of that.

Alan. I'm getting everybody out of order here, so let me just pause for a second and say --

COMMISSIONER WEIL: I was going to say I can't imagine I was next.

CHAIR THOMPSON: Alan is jumping in. Bill has been waiting, and then Chuck wants back in.

COMMISSIONER WEIL: I'll try to do this. I thought I had a minute to collect my thoughts.

Speaking of institutional, the institutional memory, the reason I asked the question, I hope most of you know me well enough to know that I knew part of the answer at least. The reason I asked the question is that I am

struck that the narrative -- and here we are also on our agenda with managed care regs – the narrative of what managed care is about has shifted dramatically, and it's different for -- it's evolved.

So back in the old day, managed care for acute care populations was about reducing hospitalization by giving access to primary care. In the LTSS context, managed care was more about providing social services that meet a social need to avoid institutionalization, particularly nursing home. Now that narrative has moved back over to the acute population as the acute care system has realized that a lot of acute care costs for traditional populations are also driven by social contexts.

I feel like if at this stage of where we are and trying to think of a chapter and what the world needs to understand is that Medicaid is not your typical insurance program, and it covers services that typical insurance doesn't that meet the needs and provide dignity and livelihood for people who would otherwise really not suffer from acute conditions only but have other, much more complex consequences.

And the whole MLTSS discussion has to be grounded

in a different conceptualization of what care needs are, what management means, and without that, I'm afraid these discussions of institutional bias and of what's in the actuaries rate -- and I just think my experience is that the moment you start talking managed care, everyone's mental model shifts to acute care, and we've got to firmly plant in the ground a different model before we try to tell anyone that they ought to think about it differently.

CHAIR THOMPSON: That's an excellent point. I think that that was also brought strongly home by the panel in their discussion today, so thank you for that.

Bill.

COMMISSIONER SCANLON: I agree with Alan's goal, but I guess I also feel -- and it goes back to your approach of trying to do some things that are smaller and more incremental.

I don't think we have agreement on what we're trying to accomplish, and I think that's a fundamental problem in terms of thinking about sort of how a program should operate. And I worry a lot about the fact that words and data may be very much misinterpreted when it comes to LTSS in part because they're put into the context

of medical care, and we think of them in the same way, ROI being kind of a prime example.

When Dennis responded to that, he was talking about sort of the benefit side being brought in, not the financial benefit side, but the human benefit side, and I think that that is a critical part about this.

In my mind, I make this distinction that medical care is about your body, kind of trying to get your body to function sort of as it should

LTSS is about how you live your life with a disability, and that's very, very different because your preferences have a huge impact on sort of how well you're living your life. That's a part of it.

The second part of it is when we talk about sort of the individual satisfaction, what about their families? This movement from institutional care to home care, you can think of all the positives about it, but the other reality is that the family now has often a very significant responsibility in terms of providing care. And the question is, What does that impact for them that they have to bear?

So I feel like if we are careful in terms of the

topics that we select and we're careful about being very clear in terms of how we're defining things, then we don't have to wait until we get social consensus on what a Medicaid program should do with respect to LTSS. We cannot do any harm in the meantime by saying things that will be incrementally positive. They won't necessarily deal with the big question, but they will be incrementally positive. And I think it's important to be cautious as opposed to trying to sort of venture out into areas that really have not been well defined.

CHAIR THOMPSON: Chuck and then Tobey and then Anne is going to just jump in.

COMMISSIONER MILLIGAN: I worry that I'm making it -- I'm a little confused too about where we're heading, so let me just start there.

I think if one version is these programs are out there, they're happening, here are some considerations that are important in design, that one kind of, I think, contribution, I think there's -- but the reason I wanted just to jump back in is I did want to, I think, pick up on some of the comments that have been made and give a little bit of the critical side that you hear about managed MLTSS

compared to the fee-for-service model.

And I think it kind of cuts both ways, but I just want to be transparent about it. In a tradition fee-for-service HCBS kind of model, there is often a lot of disparity in terms of plans of care. Like somebody might get 50 hours a week of attendants, somebody might get 30 hours a week. And it might have a lot more to do with advocacy with a case manager who is building out that plan of care.

I think when you're -- well, I'll get to the second thing in a second, but in a managed care environment, it's not a medical model, and I second what Bill said. But at the same time, there tends to be a uniform assessment process, and people try to get it as right as they can get it that a certain constellation of factors and ADL deficits and comorbidities and all the rest of it produce an outcome that is a certain number of hours. And it maybe isn't as many hours as the person had in the fee-for-service environment, but somebody else might get more hours than they had in the fee-for-service environment because they weren't as good of a self-advocate.

And it gets even more complicated, if the

caregiver is a family member who is getting paid, and it's revenue into the household.

So all to say I think how we tackle this quality-of-life dimension, a standardization dimension, an equity dimension, population dimension, there are some important differences when you move into an MLTSS environment from a fee-for-service, I think, more in some ways ad hoc kind of model that's much more case manager, Medicaid recipient relationship driven.

CHAIR THOMPSON: Toby?

COMMISSIONER DOUGLAS: Yeah. I am also getting a little confused on where we're going. I really do think this distinction -- we've got to distinguish between MLTSS and LTSS, and in the case of California, I'd say for years within the LTSS, we talked about institutional bias and all the quality of life and all the values. And the question is when you move to MLTSS, what's changing, and what -- does it have a better impact on reducing institutional bias? Does it have a better impact on rebalancing care, improving quality of life? But I think if we just talk about LTSS without understanding is there some difference what that MLTSS does in driving both where care is

provided, the incentive across the system, the cost from a state and federal perspective, it is going to be -- as well as the managed care, the cost and what's happening year to year on cost. But we can look long term as well, but I think we just have to keep in mind that MLTSS is supposed to be very different than LTSS, and we need to measure and discuss whether it is.

CHAIR THOMPSON: Anne, did you want to jump in?

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I want to just remind Commissioners of a couple of things; first of all, our audience, which is Congress. And that includes both the extremely knowledgeable committee staff, but also staff in personal offices who are not very experienced and have a large plate of issues of which they're dealing with and need -- we provide an important service in helping explain some of these issues to them.

So I think before we get too existential about stuff, I think we have a responsibility to do some descriptive work. We have not really published anything descriptive on MLTSS. We talked about it in a very brief way in an LTSS chapter.

When did we do that, Kristal? 2015?

MS. VARDAMAN: 2014.

EXECUTIVE DIRECTOR SCHWARTZ: 2014. So it's been a long time.

The other thing is -- so there are a lot of issues that you're raising, but we need to be able to first, before we do anything -- and this is the trick of how to do this all in like 25 pages. What is it? What are states doing, and what do we see as concerns? Not how would MACPAC design an MLTSS program.

So a lot of the points you're raising, I think can fit into that, but I would think that's the approach that I think the staff would take, and I just don't want to raise that now.

There will always be places where you can say to us, "You need to do a better job of expressing this point, or you need to add a section on that point," but I think that that's our starting place. And then we can tee up whatever things we want to work on more from that.

You can be strongly directional in your comments, particularly in the latter half of a chapter like that. It's not like you can't say anything, but I would start from here's what it is, here's the trend, here's why states

are doing it, and then here's some of the issues from some of the things that we've heard from this panel and the prior panel.

CHAIR THOMPSON: Yeah. What I would like to suggest is, because there are so many threads that we've discussed here this afternoon, and we did it in the earlier discussion with the state officials as well.

What I would like to ask is if the staff can come back with an outline of a chapter. That way, we can kind of see the kinds of topics that will be handled and have an opportunity at that point, I think, to help focus like we'd like more on this, less on that, and also that might be a good jumping point to what is not going to be handled in the chapter that we might want to have a little bit of a discussion about how much work we'd like to commission going forward in some of those areas.

I do think that the descriptive chapter about what's happening with MLTSS, bringing in some of the recent experiences and some work that's been done by outside organizations about what works and what creates problems and what are some of the best practices and identifying some of these other areas for future discussion and

appreciation, I think would help.

And I do like some of what we've been discussing -- what we heard in the panel and some of what we've been discussing here about making sure that people understand -- understanding that different people may have different perspectives on this, but what it is we think this really is in terms of a movement to manage long-term services and supports and what that is trying to achieve.

Okay. Thank you, Kristal. Much appreciated.

All right. So we're going to go ahead and move on to hospital payment, and Rob Nelb.

MEDICAID HOSPITAL PAYMENT POLICY ISSUES AND COMMISSION ANALYTIC PLAN

* MR. NELB: Last but not least, our favorite topic of hospitals.

I'm going to discuss a proposed work plan to help guide the Commission's work to examine a hospital payment more broadly.

So I'll just begin by reviewing some background on hospital payment and by discussing MACPAC's framework for evaluating Medicaid provider payments, which was published in the Commission's March 2015 report to

Congress.

Then I'll walk through some policy and analytic questions that could help guide our work on hospital payment policy specifically that are based on the Commission's payment framework and organized into the categories listed here.

Today, as we start this work, we are really going to be looking for your feedback on whether we're framing the policy questions the right way and whether the analytic work that we're planning to pursue will provide the information that you're looking for in order to discuss those policy questions and issues.

Based on your feedback today, we'll begin to collect some of the information described in this work plan and then share findings with you as they're ready over the course of the year or potentially longer.

So first, some background. According to National Health Expenditure Data, Medicaid spent a total of $189.8 billion on hospital care in 2016. Hospital payments represented about a third of total Medicaid spending, and Medicaid payments to hospitals represented 18 percent of all payments to hospitals.

States make a number of different types of Medicaid payments to hospitals and have broad flexibility to design their payment methods.

In fee-for-service, Medicaid makes both base payment rates for specific services and also a variety of supplemental payments, which are lump-sum payments that are not directly tied to a particular service.

In 2016, about half of Medicaid fee-for-service spending to hospitals was base payments and about half was supplemental payments.

States also make managed care payments to hospitals, and managed care spending overall is about half of Medicaid spending, but we don't have hospital-specific data on managed care payments to hospitals.

So to help guide the Commission's work on payment policy more generally, MACPAC developed a framework for evaluating provider payments. That was published in our March 2015 report.

This framework is built on the principles described in Section 1902(a)(3)(A) of the Social Security Act, efficiency, economy, quality, and access.

And one of the goals of the provider payment

framework is to really help define some of these statutory principles and discuss how they relate to each other.

So first, the framework discusses the principle of economy, which for payment purposes is really a measure of what's ultimately spent on provider payments.

Second, the framework discusses the principles of access and quality, which are distinct but related goals, that ultimately measures what's obtained as a result of the payment.

And finally, the framework discusses the principle of efficiency, which is a measure that compares what is spent to what is obtained, and this requires some consideration of all the other Medicaid payment principles.

Collecting information about the extent to which payment policies are consistent with these principles is difficult, and so the chapter talks a lot about some of the different data challenges that we have.

And it concludes by discussing three types of information that are especially needed to do further work in this area.

So first, we need more information about payment methods, such as what is the payment rate and what is it

paying for.

Second, we need information on payment amounts, including information about how much is paid and how those payments compare to other payers.

And finally, we need information about outcomes related to the payment, the effects of the payment policy on access, quality, and overall program spending.

So our proposed hospital payment work plan that we're going to talk about today aims to collect information about all of the various components of our provider payment framework. And for our discussion today we've organized the various work based on underlying policy and analytic questions.

So first a little terminology we used here. The policy questions are really intended to help frame the policy issue, and then the analytic questions are aimed to describe the types of information that's needed to inform each of the policy questions. Finally, for each analytic question, we've outlined various specific analyses that we plan to conduct to really collect and review available data to inform each of the analytic questions.

In describing our analytic work today I'm going

to walk through some analyses that we've already completed, some planned analyses for the coming year, and some topics that are still in the early stages of exploration.

There is a lot here so in the interest of time I'm just going to give some highlights in my presentation today, but more information about each of these projects is in your materials, and, as always, stop me if you have any questions.

The last thing, before I start walking through the specific projects, is just a reminder again that today we're really looking for your feedback on whether we're framing those policy questions correctly, and whether the information that we're proposing to collect is the type of information you need in order to weigh in on some of those policy issue.

All right. So let's start with payment methods. Here, the main policy question we're trying to get at is why do states choose particular payment approaches. To inform this policy question, we've outlined four analytic questions. First, just understanding, at a base level, what are the differences in how states pay hospitals today. Second, since we know that many hospitals contribute to the

financing of Medicaid payments, we want to know more about how the financing of hospital payments has evolved and how it relates to state policy choices. Third, we want to know more about the types of hospitals that receive special consideration in Medicaid hospital payment policy, whether they're rural hospitals, DSH hospitals, teaching hospitals. And finally, since there are so many different types of Medicaid payments to hospitals, we want to know a little more about how these different types of payments interact.

So our work so far on payment methods has largely been descriptive. Most notably, we've compiled compendiums of state fee for service payment policies for both inpatient and outpatient services. Our team, led by Kayla, Madeline, Daniel, and Ben, have been busy updating our inpatient payment compendium, which should be available very soon. It’s a lot of hard work going through all the state plans, but we have a good foundation of at least knowing, on the fee-for-service side, about what states' current payment methods are.

This spring, after we've updated our payment compendium, we plan to publish an updated brief describing general hospital payment policies, and we're also hoping to

compile a brief that summarizes some of the payment adjustments that states make for rural hospitals, especially critical access hospitals.

This spring, we're also proposing to look more closely at state policies for making UPL supplemental payments, the upper payment limit, non-DSH supplemental payments. And for that we can use some information we've gathered from our compendium, as well as some new information that CMS has shared with us from their UPL reviews.

To learn more about some of those broader questions about how states develop their payment methods and how the payment methods interact, we're proposing to conduct a series of informant interviews with states over the summer, to talk to them and other stakeholders about recent changes that they've made in their hospital payment policies. These interviews could also provide us an opportunity to learn about some areas that are not included in our compendium, such as managed care payments to hospitals and how changes on the fee for service side might be affecting how managed care plans are paying hospitals

Next we're looking at payment amounts. The

ultimate policy question here is, are Medicaid hospital payments adequate? That is adequate relative to costs and adequate relative to other payers. It's a tricky question to answer, and we know our ability to examine it is limited by the limitations of available data. That being said, we do plan to continue our analytic work to learn more about the Medicaid payments that hospital currently receive, continuing our work to better understand how those payments change after accounting for supplemental payments and provider contributions to the non-federal share.

Once we know more about the payments that hospitals actually receive, we can explore some of the other analytic questions listed here, including how Medicaid payments compared to other payers, such as Medicare, and how Medicaid payments have changed over time.

So this slide sort of highlights some of the work we've done so far on hospital payment. In April of last year, we published a hospital inpatient payment index, that compared fee for service payments across states into Medicare. And then, as part of our annual report on Medicaid DSH payments, we reported on hospital payments relative to costs for DSH hospitals. In December of 2016,

we built on this DSH analyses to also look at how those Medicaid payment-to-cost ratios changed after taking into account provider taxes and intergovernmental transfer that are used to finance Medicaid payments.

Moving forward, we plan to build on these analysis by taking a closer look at some newly available state evaluations of Section 1115 Uncompensated Care Pools. These evaluations are now available for eight states and provide some additional information about Medicaid payments and costs at the state level that are a little more detailed than what we have nationally.

We're also planning to begin a long-term project that begins to look at the variation in Medicaid spending across states, using claims data, and this project might provide some additional insight into how variations in the use and intensity of hospital services affects Medicaid spending overall.

The next piece of information in our payment framework is information on payment outcomes. Here we're asking kind of the big policy question of how do Medicaid payments promote the statutory goals, and to what extend are existing policies consistent or inconsistent with these

goals? However, because of the lack of outcome data related to specific payment policies, our analytic work in this area is primarily focused on looking at the incentives that the payment methods create. So we may not be able to know as much right now on particular outcomes but we can at least look at the way the methods are designed and see if they're steering towards those outcomes that we want or not.

The first analytic question is one we've done a lot of work on, how are Medicaid payments used in delivery system transformation, looking at some of the new payment approaches and incentives that states are creating. We're also proposing another question that's kind of the flip side of this question, which is how do existing payment methods maybe create barriers to delivery system transformation. And finally, although we don't have much outcome data now, we can explore more what might be some of the best measures to assess access and quality for hospital care in Medicaid.

So this slide highlights some of the work we've done so far on delivery system reform, a bunch of different projects, including, the DSRIP project we discussed with

you last fall. However, as I mentioned, we haven't done as much work looking at those payment policies that might create barriers to delivery system transformation so we're proposing to explore more work in this area.

Specifically, we could look at some of the states that still use per diem methods to pay hospitals, rather than diagnostic-related groups, or DRGs, which is the predominant payment method used by Medicare and other payers for inpatient hospital care. In addition, we could look at some of the effects of using cost-based payment methods to pay for supplemental payments, such as DSH.

All right. The last part of our proposed work plan is to examine policy options that might better promote the statutory goals. A real important policy question to guide this work is -- is the question, how can policymakers balance state flexibility and accountability? This is particularly important for the issue of Medicaid payment policy, since we already know, from the get-go, that there's such wide variation in how states pay hospitals today. But just because there's variation doesn't necessarily mean that, current payment policies aren't promoting the statutory goals. And so we will be trying to

get behind that and think about what variation we want to see and what variation we don't.

We've proposed two analytic questions here, based on the work we've done so far, and, of course, this list may evolve as we do all our other work to look at hospital payment methods and payment amounts. You may identify other areas and policy options you want to further explore.

So to look at whether payments are targeted to the hospitals that need them most, the Commission reviewed a number of policies to improve the targeting of DSH payments in its March 2017 report, including an analysis of the effects of raising the minimum eligibility criteria for DSH payments from 1 percent Medicaid utilization rate to a higher level. And then, to look at some of these questions about whether current federal oversight processes are effective, we're thinking of examining CMS's process for overseeing UPL limits this spring.

Moving forward, we could also further examine oversight processes related to hospital payments and managed care, particularly the new and growing use of directed payments, which are similar to supplemental payments in fee-for-service delivery systems.

So as you can see, we have our work cut out for us, for the year ahead. We look forward to your feedback today, and based on that feedback we'll begin to gather some of this available information and present findings as they're ready. As I mentioned, this spring we are planning to present some initial analyses of Medicaid shortfall and UPL payment policies, and this fall we anticipate that we could share some findings from informant interviews with states, if that's a project you would like us to pursue.

Thanks so much.

CHAIR THOMPSON: Thank you, Rob. Okay. Marsha is going to kick us off.

VICE CHAIR GOLD: Yeah, hi. A lot of broad thinking and a lot in here.

I just want to put another maybe two analyses on here that are omitted or maybe change some of what you have here. We talked about it a little before. I mean, I was struck, in looking at this, that there's sort of a comprehensive way of looking at hospital payment that seems very fee for service based, when we know that the managed care is getting a larger share of the sector. And I was trying to think if there's a less-siloed way to think about

it, what else do we want to know?

And so one of the questions I'd want to know is how Medicaid generally is driving hospital payments, so that knowing, with both in the rate-setting methods and in the contractual requirements, are the states specifying what hospitals get paid, or how do the managed care plans decide how hospitals get paid, so we can make it a little bit more system neutral?

The other question, which gets to more general goals, that I think is interesting, is sort of what share of people, hospital payments, admissions, whatever denominator makes sense, is tied to what incentives or values? So, for example, if we care, in the program, about limiting hospital use to when it should be used, reducing infections, getting good outcomes, coordinating with follow-up care, avoiding unnecessary admissions, and those kinds of things, looking across, you know, capitated care, you know, alterative payment, fee for service payment, and performance measures, and all the rest, what sort of outcome metrics or performance are we incentivizing, as it relates to hospital care and how that relates to the broader system, and is there a way to look at whether we

think that balance is right? Because I think that may avoid, you know, is this too much, too little, or, you know, the money, but getting at what we get at.

CHAIR THOMPSON: Fred, and Bill.

COMMISSIONER SZILAGYI: So, Rob, I like how you laid it out. I think it's a great approach, the framework that you laid out. Just to emphasize, when you look at the access and quality and look at that piece, and determine, you know, what is it that you want to buy, and I think we need to broaden that sort of lens of access and quality, broader than the typical kind of hospital-acquired infections or admissions and that sort of business, which is all important. But around, particularly in Medicaid, where you want to ensure that access to care, not only for the hospital but recognize it as one piece of a bigger continuum. In fact, it should be the smaller piece of the bigger continuum.

So what else in there, in that kind of outcomes category, is it that you want to see addressed, and I would think hard about measures of access that you want to see, maybe not even the hospital providing but connecting to other providers in the community to ensure that that's

there, so we're not back to just figuring out what's the right amount to pay for an emergency room visit, or what's the right amount to pay for a hospital day. But when you're looking at what communities are providing, the real access and the types of access you want, and then you can look at methods and amounts and things like that, that you would apply to those places that really are sort of meeting the bar on things like access and the outcomes you're looking for.

COMMISSIONER SCANLON: I agree. I think the analytic framework is very good, and I commiserate with you about the challenge of the data and sort of trying to imply it, sort of, in this context.

And I guess maybe my remarks or comments are related, similar to what I just said, about LTSS, which is this worry about sort of words and concepts and data, and how to interpret them.

I'll pick up on Medicaid shortfalls sort of as an example, which is that hospitals, along with a lot of other entities in the economic sector, they charge different prices to different -- or earn different revenues from different sort of customers, so to speak. And while some

of us may be, sort of, really taken aback by sort of what's -- forget about, sort of, Medicaid -- by an entity willing to accept a payment less than average cost, it actually can be in their interest to do so.

And so I think we need to be careful about sort of how we interpret that, because I don't think we want to put pressure on programs to pay more than they need to pay to get access to care.

And I will sort of carry that over a little bit to this issue of comparing to other rates. I mean, I think Medicare is potentially the soundest comparison, because the Medicare rates have been rooted in the cost of care. Now there's been sort of more deviation from that in recent years, but even there there's a distribution of deviations between the cost of a hospital and what the Medicare is currently paying. And I think there, you know, as you look at sort of differences, essentially, in the margins that hospitals are in, on Medicaid, it's important to think of what MedPAC has been doing with trying to identify the difference between an efficient -- a hospital that is efficiently providing care and one that may not be. And I think -- and so, again, we don't overreact to the average

but we focus sort of on sort of what is the, kind of the appropriate sort of comparison.

And when we look over to the private side, we're learning more and more about how private prices really may be a function of leverage as opposed to efficient costs of care. And so I think if we make comparisons to private prices, we need to be very careful about sort of which ones we compare and sort of them how we interpret that.

CHAIR THOMPSON: Rob, thank you very much. I think this is very responsive to what the Commission asked you to do, which was to give us something that would allow us to think about where all of the different analysis connects up and how we can speak more broadly to what's happening with hospital payment in Medicaid. So I think this is terrific and spot-on, and really appreciate all the work that has gone into this so far, and look forward to a lot of those results.

Before taking any public comment, I did want to just acknowledge, of course, that this conversation -- and I hesitated about saying something along these lines, just because we keep broadening this conversation. And I try to balance conversations so that they can actually get

somewhere and at least speak with some rigor, to some specific issues.

But this is a conversation happening in an era of provider consolidation and conversation about hospitals and their role in communities and whether -- how they invest on the inpatient side versus the outpatient side. So I just hope that as we do some of this analysis we can keep some of these elements of hospital characteristics in mind as we distinguish about how states pay, in some cases, and the plan. You know, we seem to be talking about states paying hospitals as though all hospitals are the same or all hospitals are being treated the same, and, of course, we know that isn't true, and I know that you know that isn't true, and that's reflected elsewhere in the plan.

But I just wanted to acknowledge that, as part of the -- there's a market out there that's bigger than Medicaid. It's our entire health care system. And there's a lot of forces at play that are bigger than just what Medicaid is doing. And so I would not want us to be completely blind to understanding all of those elements and forces as a part of the picture, without necessarily asking you to now take the theory of Medicaid everything and to

the theory of health care everything.

Okay. So let me pause for public comment on this or other -- any other issues that we discussed in the Commission today.

PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: Okay. So we are adjourned for day one. Thank you.

* [Whereupon, at 3:45 p.m., the Commission recessed, to reconvene at 9:15 a.m. on Friday, January 26, 2018.]

PUBLIC MEETING

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

Friday, January 26, 2018
9:25 a.m.

COMMISSIONERS PRESENT:

PENNY THOMPSON, MPA, Chair
MARSHA GOLD, ScD, Vice Chair
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
FRED CERISE, MD, MPH
GUSTAVO CRUZ, DMD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
DARIN GORDON
CHRISTOPHER GORTON, MD, MHSA
CHARLES MILLIGAN, JD, MPH
WILLIAM SCANLON, PhD
PETER SZILAGYI, MD, MPH
ALAN WEIL, JD, MPP

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:25 a.m.]

CHAIR THOMPSON: All right. I'll give the one-minute warning here for everyone to wrap up their conversations.

All right. If everybody can take their seats?

Welcome to Day 2 of our January public meeting. We're kicking off today first with an update from our Executive Director, Anne Schwartz, on upcoming MACPAC activities. This will be a regular feature of our public meetings going forward so that we have an opportunity to inform the public and invite comment on work that we are undertaking, what to expect in upcoming reports and in upcoming sessions.

UPDATE ON MACPAC ACTIVITIES

* EXECUTIVE DIRECTOR SCHWARTZ: Yeah, we decided to add this to the agenda because I think it's not always -- we've always tried to be strategic about how we design the agenda for the Commission meetings, but I think it's not always evident to -- it hasn't always been evident to the Commissioners and probably not to the public about where things are headed.

Our March report is due March 15th. It will have three chapters. The first will be on streamlining Medicaid managed care authorities, and we'll finish the work on that this morning. There will be a descriptive chapter on telehealth and also our statutorily required analyses of DSH allotments and payments.

For June, at this time we are anticipating chapters on drug pricing. We had a discussion of draft recommendations at the December meeting, and we plan to finish up work on those at our March meeting. I anticipate that we'll have chapters building on the discussion from yesterday on the impact of privacy regulations on Medicaid beneficiaries seeking and receiving treatment for substance use disorders, on the continuum of care for substance use disorders in Medicaid and gaps in coverage -- that would include but not be limited to discussion of the IMD exclusion -- and also a chapter on managed long-term services and supports. We will be working on those at the March meeting and at the April meeting, which are our last two public meetings before the June report.

We have some work in the pipeline that will be shared at future meetings to continue work that was

previously presented on payment for federally qualified health centers and opportunities for multistate collaboration, so stay tuned for next steps on those.

I also want to take this opportunity to remind Commissioners and the audience of some of our recently published work: the duals data book that we've been doing for several years with MedPAC; MACStats, which we are updating in real time on the website, but we are still publishing a collection once a year, which came out in December. We recently updated our issue brief describing the financial alignment initiative, the duals demos, and we have 11 fact sheets that go into significant detail for the states that are testing capitated models. All those have been updated and are on the website.

We recently updated our issue brief on 1115 waivers, expanding coverage to new adult group to reflect changes in Iowa and Indiana. We will be adding a fact sheet describing the newly approved Kentucky waiver, and we'll update the issue brief to reflect that as well.

Coming up, I think that probably next week we will have out the next brief in our access brief series looking at the prevalence of and access to behavioral

health services for adolescents. Those access briefs have used national household surveys to look at the comparisons of experiences for those with Medicaid, private coverage, and the uninsured. This one in particular uses the National Survey of Drug Use and Health.

We have issue briefs in development on Medicaid and schools, and public health emergencies, and also contractor reports that have previously been reported on in Commission meetings on DSRIPs and on implementation issues associated with the 1115 expansion waivers.

We also, as Rob mentioned yesterday, have an updated compendium forthcoming on state policies for our hospital payment. We're also finishing up a new compendium on state policies for appeals and grievances.

For Commissioners, the new products will always be emailed to you as they are posted to the website for the public. Please, the best way to keep abreast of our new publications is to follow us on Twitter @macpacgov because we always make an announcement there when we have something new up.

For those in the public who want hard copies of the reports and data books, which are obviously larger

publications, you can get on our mailing list either through the Join Our Mailing List link on the website or simply calling the office. And if you want multiple copies of those, we would be glad to oblige.

The final thing I want to mention for the benefit of the audience, although it's actually something that MACPAC itself has little to do with, is that GAO published on January 16th in the Federal Register a call for nominations to MACPAC for a round of appointments that it will be making in May. Again, MACPAC has nothing to do with that, but it's obviously in everyone's interest that we make sure that all qualified and interested candidates are aware of it so that we have the best group possible at the table here.

So I'm happy to take any questions.

CHAIR THOMPSON: And MACPAC is the most fun you could ever have.

[Laughter.]

CHAIR THOMPSON: Let me ask for any comments or questions from the Commissioners to Anne's update. As always, it's always an impressive tally of activity that's being performed by the staff in between our public meetings

and in preparation and subsequent to our public meetings. So any questions or comments from the Commissioners?

[No response.]

CHAIR THOMPSON: Okay, great. Why don't we go ahead and turn then to our next session. We have Ben Finder, and we're going to talk about a potential recommendation on Medicaid managed care.

REVIEW OF MARCH REPORT CHAPTER AND VOTE ON RECOMMENDATION: MEDICAID MANAGED CARE AUTHORITIES

* MR. FINDER: Thank you. Good morning, Commissioners. This morning I'll present more information for your discussion of the recommendation that would allow states to mandate enrollment of all Medicaid beneficiaries under 1932 state plan authority.

We'll start with some of the revisions that were made to the chapter that provide additional context. Next I'll recap some of the questions and concerns the Commissioners raised in December about the chapter and the recommendation. I'll present some additional information that addresses these questions and concerns, which mainly fell into three categories. And, finally, I'll present a recommendation and a revised rationale for you to consider.

At the December meeting, Commissioners suggested that we provide additional information around the context of managed care in Medicaid. To that end, we added to the chapter some additional narrative that describes the history of Medicaid managed care in a timeline. You also noted that some of the examples of why a state would choose to mandate managed care enrollment were a little broad, so we've added some additional information and some more specific examples to address these concerns.

For example, when states enroll fully dual-eligible beneficiaries, Medicare is the primary payer for most acute-care services. Medicaid generally covers what Medicare doesn't, so that's some benefits like behavioral health services; some oral health services, depending on, again, whether or not the state covers these in their own state plan; and some home and community-based services like, for example, personal care attendants. For partial duals, Medicaid generally covers Medicare cost sharing.

We added some enrollment figures, too. About under 1.8 million full duals are already enrolled in comprehensive Medicaid managed care programs. Just a few states enroll partial duals in these programs. There are

seven states that require enrollment in managed care programs, comprehensive managed care programs, and six states have voluntary enrollment for partial duals in comprehensive managed care programs.

So on to your more substantial comments. You had a very robust conversation around the chapter and the recommendations at the December meeting, and some of the questions and concerns from that conversation fell mainly into three categories.

The first is that you wanted to better understand what beneficiary protections there are for vulnerable populations and what oversight is like when they're enrolled in managed care under the waivers.

Secondly, the draft recommendation that I presented in December excluded managed long-term services and supports or MLTSS programs. And as your conversation progressed, several Commissioners raised questions about whether the recommendation should be inclusive of MLTSS programs.

Most Commissioners expressed support for the recommendation and noted that the rationale should be strengthened and that the rationale rests on the existence

of robust requirements for states and plans to ensure that the needs of populations with special health care needs and concerns are met.

So Commissioners raised concerns that allowing mandatory enrollment without a waiver would compromise beneficiary protections for potentially the most vulnerable groups of Medicaid beneficiaries.

One concern was that the exemption of these populations from mandatory enrollment is a statutory statement about the importance of ensuring that their needs are met. So we reviewed the statutory and regulatory provisions that protect beneficiaries, including some of the oversight and reporting requirements. We found that while there are no population-specific requirements in statute, there are statutory requirements that managed care organizations have the capacity to provide access to care for the entire population expected to be enrolled in the program, which includes any specific population. Moreover, there are statutory requirements that states have procedures for monitoring and evaluating the quality and appropriateness of care and services for the full spectrum of populations enrolled in managed care.

So, for example, in Pennsylvania and Kentucky's 1915(b) comprehensive managed care waivers, they mandate the enrollment of fully and partial dual-eligible beneficiaries. We looked at the requirements and standards, and we found that there are no population-specific reporting requirements in these waivers, and there were no population-specific beneficiary protections. In other words, the waiver covers these populations as it covers all, but it requires states and plans to provide appropriate care for these populations.

Another concern was that the waiver application and renewal process focuses attention on the design and administration of managed care. There are other processes and requirements in place under statute and regulation that provide CMS and beneficiaries with the opportunity to assess managed care performance. For example, CMS uses the contract review process to assess MCO compliance, quality, and performance.

Finally, the draft chapter provides more specificity around what the requirements are. For example, we have added some narrative describing states' obligation with respect to access and monitoring standards, quality

strategy, care coordination, beneficiary communication including enrollment support, and the standards around grievances and appeals.

As I mentioned earlier, the draft recommendation presented in December excluded MLTSS. As the conversation progressed, two questions emerged:

First, what effect would the recommendation have on the administration of MLTSS programs?

And, secondly, should the recommendation apply to MLTSS programs?

With regard to beneficiary protections, CMS generally seeks the same assurances of states implementing MLTSS programs as it does states implementing comprehensive managed care programs, which means that states assure that these programs meet access standards such as time and distance and including network adequacy requirements. States assure that these programs are monitored for quality and performance, that they comply with marketing and communications standards so that information is accessible and available to all enrollees. And states assure that these programs develop a grievance and appeal system for beneficiaries.

There are regulations that explicitly target MLTSS programs with additional requirements. For example, states must establish additional standards other than time and distance for LTSS provider types that travel to beneficiaries to deliver services. MCOs must provide assistance to beneficiaries who use or express a desire to use LTSS services. And states must ensure that beneficiaries' and other stakeholders' views are solicited and addressed during implementation and oversight of an MLTSS program.

Revising the recommendation to be inclusive of MLTSS programs would allow states to mandate MLTSS enrollment for all Medicaid beneficiaries. So a state like Illinois which mandates MLTSS enrollment under state plan authority for most beneficiaries and under Section 1915(b) authority for the traditionally exempt populations could consolidate its program under a single authority.

It's important to note that the recommendation only affects states' ability to mandate MLTSS enrollment, and so many states would continue to use waiver authority or state plan authority to make other design decisions to structure their LTSS programs.

For example, a state would need waiver authority to mandate enrollment, and an additional authority to provide LTSS benefits that are not listed in the state plan, or to establish an enrollment cap.

At the December meeting, there was some consensus around the recommendation and that the rationale should be strengthened in a couple of ways. The first is that we should make clear that the rationale rests on the standards and requirements included in the current legal framework and that these standards and requirements ensure appropriate access and coverage for enrolled populations regardless of the authority under which they are enrolled.

Secondly, that the rationale clarify that the recommendation is intended to streamline the implementation process or the application process for states and CMS. The recommendation is not intended to be incentive for states to initiate a managed care program. In other words, the recommendation is focused on how to implement a program, and states decide separately whether or not to implement a managed care program. So, for example, the decision of a state whether or not to implement a managed care program is beyond the scope of the chapter and beyond the scope of the

recommendation.

We also revised the rationale to reflect your conversation around the special attention and considerations for the vulnerable populations. Your concerns that plans and states are held accountable to requirements and standards included in statute and regulation, that ensure that these vulnerable populations are provided with quality coverage, that they're included in the design and implementation process, and that they're included on an ongoing basis, and that appropriate oversight is in place.

The rationale was revised to reflect scoring from CBO. We are very grateful to them for providing the scoring. They determined that this recommendation does not have an effect on federal Medicaid spending.

There was robust conversation around the recommendation at the December meeting, and we ended on a little bit of a cliffhanger then. I expect that the conversation will continue today, and we've revised the recommendation significantly based on your feedback. I expect that we'll probably revise it again today based on more feedback.

I'll leave the draft recommendation language up here for your discussion, and as we conclude, there are two issues here that I'm looking for feedback on. The first is whether or not the recommendation should include MLTSS programs. And, secondly, I expect that as you continue last month's conversation, you'll call the recommendation to a vote.

So, with that, I'll close, and I look forward to your feedback.

CHAIR THOMPSON: Thank you, Ben.

So the way that we're going to do this is that we're going to have a little bit of Commissioner discussion in response to the updated information and the new information that the staff compiled in response to our conversation in December. So we'll sort of manage that conversation. Then we'll open it up for public comment and then come back for final remarks and thoughts from the Commissioners so that we can take into account any wisdom from the public as we finish our deliberations. And then we'll move to a vote.

So let me open it up for conversation among the Commissioners. Bill.

COMMISSIONER SCANLON: Hi. First of all, let me thank you, Ben, for all the additional information. It was very, very helpful in terms of questions that came up sort of in our meeting.

I wanted to focus on sort of what my concern has been, which is not about the standards themselves. I mean, I think the standards themselves appear to be perfectly adequate. It's the issue of sort of oversight and compliance. And my experience has been that our ability to engage in effective oversight is handicapped by sort of the limited resources that we have available to do that function, and this is very, very true and documented countless times on the fee-for-service side. We can sort of point to sort of just numerous examples of where we've fallen short in terms of being able to assure that there has been compliance with the standards and regulations that we have.

I think that assuring compliance becomes most important for the beneficiaries that are more at risk, and we're all very familiar with how skewed health care needs are. Use the dollars as the indicator. We all have heard many, many times about that 5 percent of the people account

for 50 percent of the costs, and this is because they're very sick and they just need an incredible amount of resources. And so they're the ones that I think are vulnerable. And what I worry about with limited resources for oversight is the fact that they get lost in the big picture, that their needs are not sort of observed and sort of whether they're being satisfied or not being observed carefully enough, and, therefore, thinking the triaging of sort of oversight is a very important function.

Right now I don't see that we have sort of provisions to make that happen. I feel like the statutory provision is an indication in that direction, though I can't comment on what the intent of Congress was in including this statutory provision. And it's pointing in the right direction, but it's certainly not a great solution to this problem. It's not an explicit sort of acknowledgment that oversight is what we really -- you know, targeted oversight is what we particularly need. It's not even a good sort of -- if it were a target for these groups, that's not perfect either because these are eligibility categories; they're not need categories. And if you think about sort of the need, we could have people

sort of that are eligible because of family status who are as profoundly needy and we need to be concerned about them sort of as well.

So I feel like that we have an issue here, and that I don't want it sort of to be lost if we were to pass this recommendation. My hope would be that -- my ideal hope -- but I think it's too late for this -- is that the recommendation would be broader in terms of trying to deal with the issue of targeting. But my other hope would be that the Commission as we move forward would take on this question of compliance, that it's not just a question of standards, it's a question of how do we really assure that there is compliance with those standards.

Thanks.

CHAIR THOMPSON: Yeah. I just want to say that I think that that's well said, Bill, and I do in my own mind distinguish between those two things that you talked about, which is, one, as I was contemplating this recommendation in some of our earlier conversation, I went back and said, "What does the statute really say about 1915(b)?" Does the statute -- which is, of course, what we're recommending amending -- does that really provide for an avenue to

address the issues that you're facing? And the answer is it really does not.

Really, the only thing that it seems to do is to -- I mean, it calls out in very general language, and if anybody wants to pop up the language, we can look at it. But, I mean, it has very general language about assuring the quality and economy of care and makes a nod to showing cost effectiveness. And really, in the 1915(b) process, this cost effectiveness test is really one of the bigger pieces of the administrative burden involved in seeking and receiving 1915(b) approval, which requires some actuarial help and so forth. And so that's one of the places where the resources end up going.

And I do think your point about we need to conserve resources and identify where we need to prioritize the attention is another argument for help moving this to a state plan authority, so that to the extent that states are -- we've, as MACPAC, talked about state resources and how squeezed the states are in terms of being able to have all the resources necessary in order to engage in the oversight that you're talking about and some of the other things that we touched on even yesterday, about readiness and

implementation and engagement and those kinds of things that help make a managed care system successful.

So some of what you said is actually why I would be supportive of the recommendation.

Alan and then Chuck.

COMMISSIONER WEIL: I think I come somewhere close to Bill, but I come at it slightly differently. And I guess I'd just like to express that.

Rather than compliance, I think this is capacity competency, which is a little bit, Penny, where you just were.

And I guess I do worry that we've started to talk about managed care as routine and commonplace, and I guess my feeling is managed care is hard, and it requires particular capacities within the plans to effectively manage and within the states, and they are to oversee, and they are different competencies than required.

And as the person who ran the Colorado Medicaid Agency when we transitioned the moms and kids to managed care, I saw how much the staff who had been trained on rate setting and provider and enrollment had to move to a contract oversight, and these were not competencies we had.

The good news is we've had a period, and we have states that have led the way, but from an evidence base, I think we know that managed care has the potential to improve. And we tend to bring the leaders to talk to us, but we also know from the evidence that managed care has the potential to either misuse resources or harm care for the enrollees.

And so, to me, the difference between success and not success is not just the oversight. It's about competency, capacity, and maybe I'll add a third, which is commitment, particularly commitment to the positive potential of feedback through engagement with the enrollees, which some states do quite effectively, as we heard yesterday. And I think we have to be honest that many states did not.

So where I go is the existence of multiple waiver pathways does not in any way enhance the likelihood that the capacities, competencies, and commitment will be in place. So what it takes to succeed doesn't align with the processes that you have to go through to get the waivers, and so to me, as I say, I think I land where Bill does, but sort of from the opposite direction, which is if this is

what it takes to succeed and we actually now have an evidence base that it does and this is -- these are the structural requirements that we're currently imposing, those structural requirements don't align with the likelihood that you have those three elements in place.

And so, like Bill, I think it would be nice to sort of take on the broader issue of what would the structure be, what's the appropriate federal oversight, what's the appropriate state role. That's a little bit beyond where we are, but I think it's possible to just look and say these structural provisions in statute don't line up with the evidence for what it requires to succeed, and so let's not pretend that somehow by having them, we're increasing the odds of success. And that's more how I reach a similar conclusion.

CHAIR THOMPSON: Chuck and then Marsha.

COMMISSIONER MILLIGAN: Ben, thank you. I think you really did a good job addressing the cliffhanger and kind of getting us to today.

I want to align myself with some of the comments I've heard but maybe come at it from another direction, if there is another direction.

I don't think a 1915(b) requirement changes any particular outcome other than administrative burden. I don't think it -- as CBO acknowledged, I think, I don't think it leads more states to pursue managed care than otherwise would have. I think states make a policy decision about whether they want to do managed care and then look for the vehicle, and if the vehicle is administratively burdensome under the rules, they do that. But I don't think it creates an incentive to do managed care.

So I think I'm uncomfortable for this turning into a debate on managed care. To me, I don't think it influences particularly whether a state pursues managed care or not.

I do acknowledge and agree with Bill's comments about beneficiary protections and special needs populations. I am personally more comfortable voting in favor of this recommendation, when we get to that point this morning, by virtue of the existence of the managed care rule and a lot of beneficiary protections. I think that that to me is an important component.

But I see this -- I mean, we talk often about

state capacity in our commission meetings and state resources, and I think if there is an opportunity to simplify process without harm, we should take it. And to me, this recommendation moves us in that direction.

VICE CHAIR GOLD: I won't sort of -- a lot of what people said resonates with me.

The one point I wanted to raise, I guess part of me is like of all the -- I'm not sure how much administrative simplification this creates for states because of some of what I've created, but what's been discussed.

And I'd feel more comfortable dealing more comprehensively with some of the issues people have raised, and I'm particularly concerned with the dual eligibles. I know you tried to clarify it, but I'm not even sure what some of the existing state policies mean for beneficiaries.

I'm very much supportive of managed care for dual eligibles, but if it's going to include acute care benefits, I don't understand how you can do that without integrating with Medicare. And that's a complex issue.

I would prefer for dual eligibles that the focus be on what states are doing now, how to improve that. I

know that's areas we worked on.

I'm a little concerned about siloing, that there's this sense that it's okay for a Medicaid program to have a beneficiary in managed care, even if they're not in managed care in Medicare or even not in the same program, because somehow it's okay. But it isn't when Medicaid is mainly paying cost sharing, which interacts so much with those.

I don't have the same concern with the special -- you know, the carve-outs and that kind of stuff.

So I'm a little concerned that this muddies the water on dual eligibles, especially -- and also the partial versus full duals at a time when I actually think that there's more interest in the policy environment and dealing directly with some of the problems with that. And I'm a little concerned this sort of could be taken to affect the Medicare statute and the protections beneficiaries who are dually eligible have there, and its' just muddy to me. So that's a particular concern I have.

It's not the intent of the Commission, I understand, but the question is how statute gets enacted and what the ramifications are. There could be some

unanticipated effects.

CHAIR THOMPSON: Kit.

COMMISSIONER GORTON: Thanks, Ben, for the work clarifying. I agree with everybody else that I think it was a good product to start with, but I think this helps.

I just want to -- we spent a good bit of yesterday talking about MLTSS, and I was one of the ones who raised the question last time about shouldn't we just include MLTSS. I want to make sure I understand what you said, which is the recommendation focuses on eligibility. Can we mandate that people participate in these programs or not?

CHAIR THOMPSON: Right. Can you put back the recommendations that we had, as Kit is talking?

COMMISSIONER GORTON: The other conversation that the Commission is having about MLTSS as a benefit, as a delivery system, those things, they're not impacted by this. It's merely if a state chooses to build a program, and I think my understanding is that a state doing that would continue to use multiple authorities, that they might use 1932 authority in terms of saying with the recommendation, "Okay. You have to be in this program."

But they would probably still need C waiver authority to do enrollment caps or benefit extensions or some of the other things that they might want to do.

So this recommendation really -- am I correct that this recommendation really focuses on that very narrow question of can a state say to its beneficiaries that they must participate in an MLTSS program?

MR. FINDER: Yeah. I can clarify that. That's correct. So this would allow states to say you have to enroll in a managed long-term services and supports program.

States can allow those beneficiaries to voluntarily enroll under state plan authority but can't mandate their enrollment.

So states in order to implement an MLTSS program generally need two authorities. They need one authority to mandate enrollment in the managed care program and a separate authority to provide LTSS services. Whether that's 1115 waiver authority, 1915(c) authority or 1915(i) state plan authority. And they can make other design features, as you mentioned, under the LTSS program, other design decisions under the LTSS authorities.

But this just says that you can enroll. You can require enrollees to enroll in a managed care program.

COMMISSIONER GORTON: Thank you.

CHAIR THOMPSON: Brian.

COMMISSIONER BURWELL: So I both agree and disagree with Bill and Alan.

And I agree that managed care often falls short of our definitions of success or quality or whatever in terms of protecting dual eligibles and other special needs populations, but I don't think it's fair to have this conversation without talking also about the alternative. And the alternative is fee-for-service.

So my feelings on this issue stem a lot from my own observations about differences in quality for these populations between their enrollment in the fee-for-service model versus the managed care model.

And you heard from people like Dennis. I've had many conversations with consumers and with health plans about their experiences before their enrollment in managed care and afterwards, and almost uniformly, the response is the care is of higher quality. And their experience is better. They are at least engaged.

In many instances, my conversations with health plans, the experience of care prior to managed care enrollment is basically no care. There is no engagement with a care system whatsoever.

So, I mean, I agree we need oversight and compliance, but to me, that's totally a separate issue from a delivery model. And to me, there's no special need to put more barriers in front of states to design and implement a managed care approach to a fee-for-service approach. I just don't see any justification for that.

CHAIR THOMPSON: Peter, then Toby.

COMMISSIONER SZILAGYI: First, I'm in favor of the recommendation. I just want to present the pediatric standpoint.

Nearly two-thirds of children who are eligible based on SSI are already enrolled in managed care, and I don't know. Maybe almost half of kids in foster care, 40 percent of kids in foster care are already enrolled in managed care plans.

And what I see across the country is tremendous variability in the quality of care, and it's difficult to tell about health outcomes, but at least in terms of the

quality of care, the variability is greater than a clear consensus about whether it's better in fee-for-service or in managed care. It's far greater.

So it's kind of the same point that Brian was saying. I see across the country, many examples of excellent quality of care in some fee-for-service foster care programs and in some managed care programs and examples of very poor quality of care. So I think it's more the capacity, the expertise, all the other points that were brought up from the pediatric point of view. That accounts for the -- and variability is bad. If you get variability like that, we need to start heading toward reduced variability and better quality, but it's not so much anymore managed care versus fee-for-service, as some of the other components.

You know, and I do -- having been very involved with a managed care plan for 20 years, the potential for managed care to do better is clearly there to do better than a fee-for-service environment. So I'm overall in favor of the recommendations, with some of the qualifications about the need for oversight and particularly the points that Alan made about the capacity.

CHAIR THOMPSON: Toby, then Darin.

COMMISSIONER DOUGLAS: So I align myself fully with Chuck's comments. To me, this is really around administrative simplification and fully support it.

That being said, I do agree with Alan's points around managed care oversight is really, really challenging, and I think as we explore future activities, I think it would be very good to examine what does it take for states to be high performing, active regulators over managed care plans, and what are the tools and requirements?

States grapple with this, and they don't -- in many cases, the agencies get support to build those infrastructures, and I think it would be a good area to examine what are those tools they need and any recommendations on how states should be thinking about their structures.

CHAIR THOMPSON: Let's have Darin, and then we'll open it up for public comment before we continue our discussion.

COMMISSIONER GORDON: I agree with Toby. I see these as separate issues, and many folks have said that.

This is about utilizing the capacity at Medicaid agencies in the most efficient, possible way, and if we can give them avenues to do that, then I think that would be a good thing.

It's more than just the cost-effectiveness stuff. It is -- every wavier you have, you have numerous interactions with CMS, different reporting requirements on each and every one of them. And having my staff focused on that administrative responsibility of multiple waives really took our focus off how we're improving the program and serving the populations for which we were responsible for.

And so simplifying that doesn't mean you lose the engagement or the interest or the focus on reporting and the interactions with CMS, and I say this as a person who consolidate our waivers under one single waiver to try to maximize that.

What we had happening when everyone had multiple different waivers, we had our LTSS group having phone calls updating a subset of folks within CMS of what was going on there and reporting to that subset.

We have different calls over here on the

different waivers with different people within CMS, reporting to them and having different discussions there, which really led to an inefficient way for CMS to look at really what was going on collectively for these members that we're responsible for.

So to the extent you can bring it -- you know, simplify things, bring things together, and look at things more holistically, without degrading oversight and all the things that are said -- I mean, we could spend a great deal of time, and I think we should, about what are the proper things to do around oversight. I think those are well said, but simplification and maximizing the resources at states so that they can focus on the things that are most important I think is the right thing to do and why I would be supporting this recommendation.

CHAIR THOMPSON: Let's open it up for public comment, so we can take that into consideration before completing our conversation and voting on the recommendation.

PUBLIC COMMENT

* MS. DOBSON: Yeah, Brian knows I'm not really tired of speaking.

Camille Dobson. I was here yesterday, but I speak today in a slightly different context. I was the Senior Policy Advisor at CMS for five years, in charge of the unit that did waiver approvals, and I will tell you that I echo all of the comments that Ben -- the recommendations that were put forward.

Truly and honestly, it's an administrative burden, both for the states, for my team, where we were reviewing state plan amendments for managed care and for waivers. Multiple states have not both (a)'s and (b)'s, because they wanted to move quickly, and the waiver process, honestly, is not -- we had a 90-day clock. We would typically stop it. That's another 90 days. A state was now six months to a year before they could implement a managed care program.

The waiver document that we -- the states use is not a PRA-approved document. It is an inherited document that I receive from Bruce Johnson, who made it up sometime in the '80s, and it could be changed tomorrow by CMS, to take out all the things that the states currently report on. So, fundamentally, the protections that states need to have in place are all based in the regulations,

which are agnostic to authority. They apply across the board, to 1115's, 1915(a)'s, (b)'s, and (c)'s.

I agree with Ben that most of the oversight today comes from the contract review that's done at the regional office level. I will tell you, when we were drafting the first round of the managed care regs, one of the things that really bothered me is that based on the authority the state used, we didn't get the same information.

And so one of the things that I know the states hate, but I thought was really important and put in the, at least the first draft that was out before I left, was a program report, so that regardless of authority, the state was reporting the same information about beneficiary protections and grievance and appeals and quality, so that you would not have to worry about having a different level of oversight or CMS monitoring, based on the authority.

I will tell you, I think -- I'm not sure who it was raised the fact that age, blind, and disabled folks can be mandated under (a), and their health needs are maybe not so different than the dual eligible, which you have to use a different authority. So, frankly, the eligibility door that you come in really doesn't have anything to do with

the protections, the oversight that are done, and it is a real pain for states to do (b) waivers. I will tell you, I hated it. It was my least favorite part of the job that I had, because 90 percent of the questions we had were about cost-effectiveness. The fact that we're still having a conversation, after 25 years, that managed care isn't more cost-effective than fee for service is simply ludicrous, really.

And so the hoops that states have to jump through for a (b) waiver don't add any value, I think, at the CMS, I would tell you from the CMS staff perspective, nor from the state perspective. And the decisions of moving to managed care really are done before the authority even comes. States will try and find the most effective and efficient way to get to it. You know, Toby used to have a bunch, and California had a bunch of (b) waivers, consolidated them into 1115's, so did Tennessee, so did New Mexico. So there are a number of states who have figured out that having multiple authorities isn't helpful. Because you can't use the state plan, you only can go up. And so the states now jump to an 1115, which is its own hornet's nest of issues to deal with CMS, having worked at

that unit for five years too.

So I just can't say strongly enough. I can't speak for the Medicaid directors. I'm hoping somebody is here from NAMD, to speak on behalf of this recommendation. But I can tell you, from a CMS perspective, that it would add a lot of value to free up staff time from doing waiver renewals to focus on contract monitoring and oversight, from the CMS perspective.

CHAIR THOMPSON: Thank you, Camille. Other comments?

[No response.]

CHAIR THOMPSON: Okay. Further discussion? Have we exhausted the topic?

We do have several Commissioners who are not present today, so they will be unable to vote on the record. However, two of those Commissioners, Commissioner Davis, Commissioner Retchin indicated their general support for the recommendation, providing some of the same commentary as we've had here in the public discussion. And so that will be reflected in the chapter as we finalize it.

So we have the recommendation in front of us to vote. We will -- based on this conversation, just as

people take this into consideration as they vote yes or no on this recommendation, we will ensure that the chapter is fully reflective of this discussion, fully reflective of the fact that this is focused on authority for states to proceed with managed care, that is intended to promote administrative simplification, to conserve resources.

It is not -- the Commission continues to be interested in exploring, in the future, ideas about how states can be as successful as possible in implementing managed care programs through their capacity, their competency, as Alan described, through readiness, through preparation, implementation, engagement, and oversight, and so those issues remain on the table for us, including continued review and analysis of the current regulatory approach and its success in helping produce proper outcomes.

So let Anne now take the roll and we'll compete our voting.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. And I just want to also just mention again, we mentioned this in December when we did the votes on the prior two recommendations that will be included in the chapter, that

the conflict of interest committee met in November -- you have the date.

CHAIR THOMPSON: I'm supposed to say this.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah.

CHAIR THOMPSON: Yeah, it was November.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. Okay. So we met in November. There were no conflicts at that time.

Okay. So I'll call the roll and the vote is on adoption of the recommendation language -- my sheet says it's attached but it's what's on the screen there.

So, Brian Burwell.

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter.

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise.

COMMISSIONER CERISE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Gustavo Cruz.

COMMISSIONER CRUZ: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis, I'm marking as not present, per Penny's comments.

Toby Douglas.

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George.

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Marsha Gold.

VICE CHAIR GOLD: Let me hold it and then come back.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. Okay.

Darin Gordon.

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton.

COMMISSIONER GORTON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin, I'm marking as not present.

Chuck Milligan.

COMMISSIONER MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin is also not present but shared his support with Penny.

Bill Scanlon.

COMMISSIONER SCANLON: Abstain.

EXECUTIVE DIRECTOR SCHWARTZ: Abstain. Peter Szilagyi.

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Alan Weil.

COMMISSIONER WEIL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. And I can come back to Marsha, or you can vote, Penny.

CHAIR THOMPSON: I'll vote.

EXECUTIVE DIRECTOR SCHWARTZ: Okay.

CHAIR THOMPSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Marsha?

VICE CHAIR GOLD: I'll abstain too.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. So we have 3 not present, we have 2 abstaining, that's 5, so that means it was 12 voting yes, and that will be -- the record of the record of vote is included in the chapter, per our statutory authority, and will be included in the chapter.

I want to say, for Commissioners, Penny has talked individually with a number of you about reviewing the full draft chapter again, before it goes into production. It will take us some time, at the staff level, you know, Ben, to get -- we've already made a bunch of changes in the chapter, as he mentioned, but we now need to incorporate the discussion and go over it. I think we need to add a paragraph on future work.

CHAIR THOMPSON: Mm-hmm.

EXECUTIVE DIRECTOR SCHWARTZ: So it's not going to be until, I would say, the end of next week before we would be able to get it to you, in which case we need like a super quick turnaround on it, to make sure that we hit our March deadline.

CHAIR THOMPSON: And any Commissioners who are particularly keen in being involved in that review, let me know. Otherwise, I will hit you up.

Okay. Thank you, Ben. Thank you, Commissioners.

Okay. We will go on now and talk about Money Follows the Person.

REVIEW OF HHS REPORT TO THE PRESIDENT AND CONGRESS ON MONEY FOLLOWS THE PERSON DEMONSTRATION

* MS. VARDAMAN: Good morning, Commissioners. Today I'm here to set up a discussion of the Secretary of Health and Human Services' report to Congress on the Money Follows the Person Demonstration.

I'll begin with a bit of background on Money Follows the Person, or the MFP demonstration program, discuss the timeline in planning for the demonstration's end. Then I will go into a summary of some of the key

findings from the Secretary's report, outline some potential areas for MACPAC comments, and then discuss next steps and the timing for submitting those comments.

First to set up some background, the Secretary was required to send a final report to the President and Congress reflecting the findings of the MFP evaluations and to make conclusions on its conduct and effectiveness. MACPAC's authorizing statute directs the Commission to review the Secretary's reports and to provide written comments.

MFP was first authorized by the Deficit Reduction Act, or DRA, of 2005, and extended by the Affordable Care Act of 2010. As of September 2016, CMS had awarded 43 states and the District of Columbia $3.7 billion to help Medicaid beneficiaries transition from institutions back to the community through this program.

The first awards were made in fiscal year 2007, and MFP assists beneficiaries specifically who reside in an institution for at least 90 days, as the change was made in the Affordable Care Act. Beneficiaries receive home and community-based services that are beyond what's typically provided on a state's HCBS programs in order to assist them

in making that community transition. And states earn an enhanced match for certain services provided through this program. Specifically, the enhanced match provides half of the difference between the state's regular match and 100 percent not to exceed 90 percent.

This enhanced match is used by states to fund rebalancing efforts. States have, for example, used funds through MFP to reduce waiting lists for 1915(c) waivers and to provide housing supports. States can also cover administrative costs, such as investments in information technology for reporting requirements under MFP, and receive technical assistance.

The final awards for MFP were made to states that were transitioning beneficiaries in fiscal year 2015. The final awards were made for 2016. However, states have the ability to transition beneficiaries using those funds through the end of this calendar year, and then they can provide services to those beneficiaries for an additional year, and must claim funds by the end of fiscal year 2020.

As part of planning for the demonstration's end, states had to submit sustainability plans outlining which services they would continue, following the end of the

demonstration. States may have done some analysis to find out which services were most well-utilized or well-reviewed from beneficiaries. States have to, following the end of the demonstration, have some way of paying for such services, either incorporating them into their existing programs, if they have not already. If they're not already incorporated in those programs there may be some budget pressure in trying to do that.

If states are not able to make these changes, there could be certain services that might be limited to certain populations, for example, those where they were offering those services to those populations prior to the demonstration. States might also not continue to provide certain services, given their analysis of what services were well utilized or well received.

Next I'll review some of the key findings from the Secretary's Report to the President and Congress.

Through the end of 2015, MFP had transitioned over 63,000 beneficiaries. That number continues to climb since states do have through the end of this calendar year to transition beneficiaries. But over the time period of 2008 to 2015, states transitioned an increasing number of

beneficiaries each year.

The report highlights some of the challenges that states encountered in transitioning beneficiaries, which included an insufficient supply of affordable and accessible housing; staff shortages, in terms of the numbers of transition coordinators and case managers available; and low numbers of referrals from nursing facilities.

Over the time period of 2008 to 2013, the report notes that there was an estimated $978 billion in savings to the Medicaid and Medicare programs. However, this includes beneficiaries who may have been transitioned in absence of the program, so it does report that this is an upper-bound limit for estimated savings.

And you can see from these figures in the slide here that in the first year after transitioning, monthly Medicaid expenditures, per beneficiary, declined in a range of 23 percent to 30 percent, depending on the population that was being served.

For beneficiaries that transitioned through the MFP program, there was some evidence that they had experienced some positive outcomes. The evaluators found

that compared to a comparison group, MFP participants were less likely to be readmitted to an institution in the year after transition, and quality of life surveys showed improvement in satisfaction with care, satisfaction with living arrangements, and fewer reports of barriers to community integration.

In addition, some other findings were that MFP funds were used to create programmatic changes to promote rebalancing, including transition service that went beyond the demonstration. There were also identified collaborations between Medicaid programs and housing agencies that the report noted were expected to continue following the end of the demonstration. And finally, the report notes that data availability was a limitation for evaluators. In some cases, some analyses in the evaluation was limited to a sample of states or sample of participants given incomplete claims data.

Next I'll turn to outlining several potential areas for MACPAC's comments. First, the Commission may want to provide comments on the MFP results, as outlined in the Secretary's report. Second, the Commission may want to make some statements on the sustainability of transition,

again, outlined in the report, and given some of the sustainability reports that we have reviewed, there are many states that will continue a lot of the MFP services and others that may be more challenged in maintaining that level of service.

Next, the Commission has repeatedly made comments about the availability of administrative data and data lags in preventing evaluations from being as full as they could be, and so the Commission may want to reiterate that in its comments. And finally, the Commission may want to highlight potential next steps in supporting rebalancing of long-terms services and supports.

So next steps following today's discussion, staff will provide a written draft of comments for the Commission's review, which will then be submitted to the Secretary and congressional committees.

Thanks.

CHAIR THOMPSON: Thank you. Before we open it up I'm going to ask Brian to kick us off, but I wanted to just ask a couple of questions. One is, in the sustainability reports, what are states saying, themselves, about their intentions once the program ends for them, or their funds

run out, in terms of their intentions moving forward? Can you just characterize that, generally?

MS. VARDAMAN: Sure. We reviewed a sample of the sustainability reports and each varied, but states generally outlined the service that they had been providing and where they had evidence where, for example, if certain services were not utilized as expected, that, you know, they would not continue those, and others that, again, they expected to continue. We spoke to several states about a year ago about their plans, and generally all expressed interest in continuing transitions to the extent that they could, but did have some concerns about the ability to do so, given the budgetary challenges, given the lack of enhanced match moving forward.

CHAIR THOMPSON: I do think that in addition to the comments on the report there's this larger question, which is, should the program be extended, where the Congress may want our advice on that. And so I would also invite the Commissioners to talk about any suggestions they have about what work we could be doing, or what advice we could be providing along those lines, in addition to commenting specifically on the report. The report itself

is not totally conclusive.

Brian.

COMMISSIONER BURWELL: [Off microphone.]

CHAIR THOMPSON: Go ahead and put on your mic, Brian.

COMMISSIONER BURWELL: Thank you for that excellent presentation. There is one typo in the presentation, on Slide 11, where you said it's estimated $978 billion in savings. It's not billion -- it's million. That would be a really good finding.

[Laughter.]

COMMISSIONER BURWELL: I guess I have three comments on the report to Congress. I think it falls short of my expectations in many ways, but those are my expectations. And I'll highlight three areas where I think the Department should have provided more information.

One is just accounting for where the money was spent on the demonstration. This was a very large demonstration. They spent $3.7 billion over the time period of the demonstration, and I feel the report to Congress is really lacking in regard to how that $3.7 billion was spent.

It talks some about, you know, the enhanced financing for people who were transitioned to the community afterwards, but what I would like to see from accounting is how much of that money was spent for kind of initial program development to the states, how much was spent for infrastructure, because there were very significant costs associated with infrastructure paying for staff to go to nursing homes to talk to people. There was a lot of money spent not only on transitioning people who eventually did transition but on people who eventually did not transition. And so kind of how much money was spent there. Then how much money was spent on regular Medicaid services, you know, waivered services once part of the community, and then the enhanced financing, et cetera.

So, to me, you know, where that $3.7 billion went to is something that I would like to know more about.

Secondly, I was disappointed in that the administration kind of took the MPR evaluation, just stamped it and sent it out as the report to Congress. The evaluation had certain objectives, certain requirements, certain scope -- this is our findings. I believe the administration should have taken those findings and added

its own, so what's next? This was a demonstration that was designed to test Medicaid policy around how home and community-based services should be financed.

You know, prior to the demonstration, we've had this great development of home and community-based infrastructure, primarily focused on diversion, identifying people in the community who had LTS needs, providing them services, and hopefully diverting them from nursing home admission. The question in the demonstration is that it was that -- that's not sufficient. Do people end up in nursing homes anyways, through various means, and that a state-funded home and community service system should also have an infrastructure component to actually go out to institutions, identify people who would rather live with the community, and transition them back into the community.

That was the question of the demonstration. I see no comment in the report to Congress about that as a potential policy. So it relates to sustainability.

You know, it was still early. There's demonstration money still being spent. But the sustainability question to me is an important one in that if states believe that, you know, the MFP demonstration was

a success, they would find ways to finance that infrastructure and those services in the absence of the demonstration. If they're not, what are the reasons for that? What financing structures should be put in place to support those transitions over time but currently aren't available on the Medicaid program and should promote that change in policy so that that infrastructure and those services could be provided? So I thought that was missing from the report as well.

I'll end there.

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: Thank you, Kristal. And, Brian, thank you. I always learn from you. I appreciate your comments and want to align to a lot of what you said.

I want to add a couple things. I was in Maryland for a good chunk of this MFP program, and we took full advantage of it. I think the infrastructure part was really important and useful. I think it would be helpful had that been called out better. And some of the IT systems and just some of the mechanisms by which plans of care were automated, eligibility was simplified and automated, all of that stuff mattered.

Two substantive comments I want to offer. In an earlier part of my professional life when I was part of a research organization, one of the things that we identified is that the longer somebody was in a nursing facility, the lower the likelihood of rebalancing. Individuals, the longer they were in a nursing facility, the more likely it is that they would have lost their housing back in the community, either a home they owned or a place they rented. Their informal and formal caregivers would have kind of moved on with their lives, and it was harder to reconstruct a community-based system of care the longer somebody was in a facility.

So I think that when MFP moved from a six-month minimum length of stay to a three-month minimum length of stay, partly it was to address that issue, that there is a cliff after which somebody has been in a nursing facility they're not going back home again, having a lot to do with the community, housing, and support system that isn't waiting for them anymore. And I think that it would have been a very important contribution to the evaluation to look at the relationship between length of stay and success in these programs, because unlike a lot of other

rebalancing efforts, this was really targeted at nursing facility length of stay as a predictor, as an intervention. And I think that that is an important contribution that should have been further developed, honestly.

My last comment is that, you know, there's a lot of other rebalancing efforts going on simultaneously, as you've noted and as the report noted, the Balancing Incentive Program, Community First Choice, a lot of states further advancing Olmstead and rebalancing policies for their own sake. And I think that the context within which MFP was a component but, you know, one part of the -- one policy intervention doesn't lead MFP to get credit for 63,000 rebalancing. So I do think that the broader context could have been elaborated. And I'll leave it there. Thank you.

CHAIR THOMPSON: Gustavo and then Kit.

COMMISSIONER CRUZ: I just have a question that is actually related to Brian's comment. The savings, the $978 million in savings, were attributed to what?

MS. VARDAMAN: So that's attributed to the reduction in per monthly cost. So if I go back to my --

CHAIR THOMPSON: It's effectively the savings

associated with being in the community as opposed to being in an institution.

MS. VARDAMAN: Right, and those numbers that were reductions in per monthly per beneficiary costs extrapolated across all the beneficiaries that were transitioned over that time period.

COMMISSIONER CRUZ: It's like less use of Medicaid services or hospital services?

MS. VARDAMAN: So compared to when they were being served in an institution, and through moving to the community, now being served through home and community-based services, even with the enhanced match there was still some savings for those beneficiaries.

CHAIR THOMPSON: Kit, Marsha, Bill.

COMMISSIONER GORTON: So I want to align myself fully with Brian's comments, and I won't repeat them other than I just want to say that I agree with them.

Like Chuck, I want to highlight that there are other rebalancing efforts that have been underway for a long, long period of time. I was in Pennsylvania when we closed six state ICFs and five state mental hospitals. And so that work is all going on in the background and I think

probably accounts for some substantial part of these savings. And it isn't going to stop. To me that says that the states who have understood the benefit of this both in terms of providing better community integrated services to people with disabilities as well as to come up with a more cost-efficient delivery system, states get it, they'll do it. You know, so I am underwhelmed by the findings of this.

And then the last thing I just want to say -- and it goes to Bill's earlier comments and some of the things that we've said over my time on the Commission and before about the inadequacy of data. How do we have any confidence or learn anything from these demonstrations if data requirements are laid out at the beginning and evaluators are hired and lots of money is spent on evaluations and then the states don't produce the data? It is troublesome to me that, again, we're in a situation where the evaluators at the end of the day said our analysis has been limited by a lack of production of the data. It wasn't like when you went -- it's a demonstration. And so when you sign up for a demonstration, you sign up to provide and participate. I

just continue to struggle with why it is, particularly as we move more and more into 1115 land, why it is that we go into these with the assurances that we're going to do an evaluation, we're going to be able to draw conclusions, and then we get to the end and we don't have the data to complete the analysis.

CHAIR THOMPSON: Marsha.

VICE CHAIR GOLD: Yeah, I appreciated your comments, Brian. Like you, I read this thing, and it's, like, okay, so what? And there was a lot of money spent, and I think that -- I'm fully supportive of our letter talking about the importance of going further with what it means and also how the money was spent. It would be useful to, as part of that, when you talk about the savings to beneficiaries, how that relates to the sunk costs of the other -- the costs of the demonstration and just what was in that analysis.

Which leads to my second point, which I really think is important. I'm not sure what's in the public domain, but I think that we should request that the full evaluation reports be released if they're not out there because that was paid for by public money. There may be

some of the questions people have here that are answered in those reports. Certainly it'll give more detail on the methods and what was happening. And I see no reason those shouldn't be fully available, and I'd like us to come across strongly supporting that.

MS. VARDAMAN: There are reports that the evaluators did publish for each year as well as progress reports, and, you know, as Brian noted, the report to Congress kind of summarizes some of those results, but really reflects the results from the 2015 evaluation report, which goes into much more greater detail about what's behind some of the general findings that are reported --

VICE CHAIR GOLD: And that's out?

MS. VARDAMAN: And that is out and available.

VICE CHAIR GOLD: And what about don't they have to do a master final report with a whole lot of detail? All those contracts include that.

MS. VARDAMAN: The last evaluation report was published for 2015, and then I believe the final report is what -- you know, that evaluation report is what fed into this report to --

VICE CHAIR GOLD: Right, that report. What I'm saying is that report should be in the public domain as well.

MS. VARDAMAN: Yes.

VICE CHAIR GOLD: It is?

MS. VARDAMAN: Yes. The 2015 evaluation report is --

VICE CHAIR GOLD: But not the -- yeah, but that's a long time ago. I mean, there's no further report and no further report planned?

MS. VARDAMAN: There is a --

VICE CHAIR GOLD: I find it hard -- people generate tons of paper on these evaluations.

MS. VARDAMAN: There is a 2016 grantee progress report which doesn't have the same kind of evaluation details. I'm not sure if there's an expectation of publishing a 2016 evaluation report, but I can follow up and see if that's the case.

VICE CHAIR GOLD: Yeah, I mean, on general principle, unless we know that they've made everything they got public, I think we should ask that it all -- that it just be there so people can benefit from whatever was

learnt or not learnt by the evaluation. I just find it hard to believe that the limited amount of stuff that's in that report to Congress with no appendices was something that got produced under one of these big evaluations.

CHAIR THOMPSON: Bill.

COMMISSIONER SCANLON: I'll pass [off microphone].

CHAIR THOMPSON: Kristal, here's a question for you. And I agree with all of the commentary about the report and what's missing and what we'd be curious about or what we even think beyond just being curious is really important, and Chuck and Brian and others have made those comments. But this report is out, right? And so I'm just trying to think about writing a set of comments that sort of says this isn't what we thought it was going to be and doesn't contain some of the information that we think is important.

That could be remedied by a couple of different things. So one is maybe the department has the information and just didn't include it in the report. And we think it ought to be included in the report, and it could be supplemental information, or we could ask them to provide

it to us so that we could produce some of the required analysis that could provide some further insight.

I think it might be worth a conversation with the department, you know, summarizing this conversation and exploring what kind of data they may have. Is it a matter of not having the data? Is it a matter of having the data but it just didn't make it in? Are there some things they could be speaking to or plan to speak to in some supplemental activity? I think we put down our markers and say our thing, but I'm also trying to think about how do we actually constructively solve some of the gaps that we're identifying as necessary to complete the picture for us and for the Congress and making decisions about whether there's any continuation that's necessary here.

I mean, I generally do agree, Kit, with you in saying that to me the value of this kind of a program is to allow states to fail, to allow states to try things that seem risky but could have potential benefits and to learn from that experience and from the experience of others in deciding how to, you know, formulate going-forward strategies.

But I also agree with what Brian said, which is

there may be some policy issues here about activities that are not matchable, connections with housing authorities particularly that, you know, would otherwise not be something that states can claim for different reasons. I'm really interested in understanding those places where, as a matter -- not just a matter of getting enhanced match, and that always helps, but as a matter of qualifying for match in the first place, are there certain kinds of activities here that we should be arguing should be part of state plan authorities or part of other kinds of waiver authorities that should be available to states outside of this demonstration?

Leanna?

COMMISSIONER GEORGE: I wanted to comment because Serenity actually came out of Murdoch Developmental Center with Money Follows the Person, so we actually benefit as a family from this program.

One thing that was very key in her transition back to the community was that access to a community-based psychologist that I was able to do before she even left Murdoch, the behavioral support plans and stuff like that she needed, so that everybody in the community that would

be working with her had access and training before she ever stepped foot out of the center, she would be able to come home and that we all were on the same page and knew what to do to improve that transition home and everyone knew what to do to keep her safe, keep everyone around her safe, and be productive with her. And I think that's one thing -- it was a billing issue that Medicaid can't pay for the institution and pay for --

CHAIR THOMPSON: Because she's already being paid for inside of the institution and for the planning program.

COMMISSIONER GEORGE: And for the community, and that was where -- you know, and that's one thing that is very crucial, at least for Serenity with the IDD problems that she has, to transition to the community. I think that's one area that we could probably address easily to improve without having a full Money Follows the Person program, but still enhance the transition home for families and kids like Serenity.

CHAIR THOMPSON: Thank you. Thank you, Leanna.

Any additional comments?

VICE CHAIR GOLD: Can I just ask Brian to clarify? I know Kristal said it. Do you happen to know

what's released in the report and whether it is in the public domain? Because I assume you probably share the view that it should be.

COMMISSIONER BURWELL: Like a lot of large evaluations of demonstrations, the timing issues are important. So 2015 was the last report of the MPR --

MS. VARDAMAN: The last full evaluation report, 2016, is a more limited progress report.

COMMISSIONER BURWELL: Right. So the evaluation funding contract ended at that point. The estimates of savings -- the quantitative analysis in the report to Congress only goes through 2013. I mean, there was a lot of delay in getting these things up and going because there's a lot of difficulty around infrastructure, et cetera. I'm not clear about all the data availability issues, but I assume they used MAX data because it was available to 2013, they were expecting to have T-MSIS data. It was not available. It's still not available. You know, so the quantitative analysis essentially ends in 2013, but CMS was still making awards, grant awards, through 2016. States can transition people still through 2018, and they can claim an enhanced match through 2020.

So this report to Congress, it's kind of still an interim report. So I have no idea if there are any intentions of continuing evaluation activities or looking kind of -- I mean, that's partly why we don't have any really good information about sustainability, because many of these demonstrations are still in process.

CHAIR THOMPSON: So it sounds like we will have a pretty fulsome comment letter, but I do think beyond that, getting the answers to some of these questions about where the data is and whether it's available and whether it's been analyzed and whether we could have it and how that folds into a discussion that we might want to have about advising Congress about elements of this program that we think ought to be normalized, standardized, moved into, you know, either a continuation, a smaller continuation, regular plan authority, I think we need to have that conversation, and we need some of this data in order to be able to do that.

COMMISSIONER BURWELL: I mean, I also just want to ask the question: Does the department intend to have any other evaluation findings from the later stages of the demonstration or something around that?

CHAIR THOMPSON: And I do think that understanding a little bit more -- maybe this is something that you can help us with, Kristal, at least what's been reported by the states in their sustainability plans, when they're going to run out of money. So when does this become an issue where, if there are activities that are being paid for now that would otherwise not be matchable, otherwise not be done by the states, not because they don't think they're important or valuable but because of other issues? When does that really come to a head so that we can kind of understand the urgency and timing around some of our deliberations and conversations?

MS. VARDAMAN: I'll just make a note that as of September 2017, CMS published a list of when states plan to end transitioning beneficiaries, and the majority were going to do so through the end of this year. Some were planning an earlier timeline to end transition.

CHAIR THOMPSON: So that's a now issue. Okay. All right, great. Thank you, Kristal.

[Pause.]

CHAIR THOMPSON: All right. Kirstin. We're going to talk about integrating appeals processes for

dually eligibles.

INTEGRATING APPEALS PROCESSES FOR DUALLY ELIGIBLE BENEFICIARIES

* MS. BLOM: Thank you, Penny.

So good morning, everyone. There's always a lot of interest among the Commissioners in issues affecting duals, both because of the complexity of their health care needs and the high cost associated with those.

So for our final session today, we are going to zero in on one of those policies, which is integrating appeals processes across Medicare and Medicaid.

A lot of the efforts that states are undertaking right now to integrate care more broadly for duals include provisions to integrate the appeals processes specifically.

Aligning or integrating appeals can reduce confusion for beneficiaries and reduce the administrative burden on both the beneficiaries and also on others, like providers, and states and the federal government.

So I'm going to talk today about the appeals process in managed care, which is where the integration efforts are occurring. I'll talk through the key differences between Medicare and Medicaid's processes and

then talk about how it works for duals when the processes are integrated.

I'll also talk about steps that the federal government and states have taken to streamline the process for duals. We'll look at a couple of examples of integrated processes, with a focus on New York.

So, as you're all aware, an appeal is an action a beneficiary can take if he or she disagrees with a coverage decision. An appeal is different from a grievance in that a grievance is more about satisfaction with the quality of care that you received.

The grievance process under current law is a little bit more straightforward and already a little bit more similar between Medicare and Medicaid. Although any effort a state would undertake to integrate appeals would also include grievances, the focus isn't really on the grievance side. It's more on the appeals because of the complexity of that particular area, so that's what I'll be talking about today.

The right to file an appeal or a grievance is based on the right to due process in our Constitution, and it appears in both Medicare and Medicaid.

In Medicaid, the two fundamental elements of an appeal are the right to be given notice of a state action regarding your benefits and an opportunity for a hearing to review those actions.

I'm sure it's no surprise to anyone in this room that Medicare and Medicaid have different processes for appeals. Obviously, for people enrolled in either program, that's probably not that big of a deal, but if you're a dual eligible, you have to navigate both of them.

The differences that exist probably reflect, to some extent, the differences in the populations covered. Medicare, for example, has a provision called "amounts in controversy," which is setting a threshold for an appeal, so an appeal can't go above a certain level unless a certain amount of dollars are in contests. And Medicaid does not have a provision like that, presumably because of the lower-income nature of the population.

Differences like this do present an opportunity for states and the federal government to improve administrative alignment.

Up until now, efforts to align, as I said -- to align appeals have occurred in managed care. That's in

part, I think, because in managed care, there's a single entity, a single decision-maker, which is the health plan where a beneficiary can begin his or her appeal.

Also, as I said, managed care is where efforts to integrate care more broadly for duals have been focused, and appeals are a part of that.

Efforts to simplify the appeals process have very much emphasized focusing or pulling in the aspects of either program that are most favorable to duals, most favorable to the beneficiary.

So, for example, in New York, they did not adopt Medicare's amounts in controversy, which I just mentioned, because that would limit a beneficiary's appeal options.

The process in managed care typically works -- it starts with a health plan in Medicare and Medicaid, and the health plan will deny coverage of a particular service, and then the beneficiary has the right to choose to appeal. The plan is required to provide instructions to the beneficiary about how to file the appeal, and the beneficiary then can make that decision for themselves and then typically has to decide which program to appeal to.

The provider probably helps with this and with

the appeal in general by providing supporting documentation, but it can be difficult and administratively burdensome to figure out which program you should send your appeals through. And in some cases, as a result of that, appeals get filed simultaneously in both programs.

This is especially true in situations where coverage overlaps between Medicare and Medicaid. So, for example, both programs cover durable medical equipment, but Medicare limits that coverage to DME used in the home. So although Medicare is the primary payer, Medicaid has a more expansive coverage criteria, which might lead a beneficiary to appeal to both programs, hoping that if Medicare doesn't approve it, Medicaid will.

Another reason why a bene might appeal to both programs is that there are time limits around appeals. Typically, a beneficiary has 60 days from the day when they receive notice from the health plan to file their appeal, and then the health plan typically has 30 days, unless there's an expedited appeal, which can occur in about 72 hours.

Another complicating factor is that if a beneficiary wants to continue receiving their Medicaid-

covered benefit during the appeal process, they only have 10 days in which to request a continuation of benefits. So it's possible that a beneficiary could run out of time waiting for an appeal to finish, to flow through one program, and would then not be able to appeal to the second one.

There have been some fairly recent policy changes around appeals. In 2016, CMS promulgated new Medicaid managed care rules, which set out to align some of the Medicaid processes with Medicare and with the private sector.

There are two main ways in which they did that. First, they aligned Medicaid's time frames with Medicare's time frames. So, prior to the rule, Medicaid, as is typical with Medicaid, had timelines that varied from state to state. There was a range of between 20 and 90 days. The rule just said Medicare's 60-day policy will be Medicaid's policy as well.

And then, second, beneficiaries had, prior to the rule, the right to request a hearing with the state before they finished the first level of appeal, which is the reconsideration by the health plan. The rule said you

still have a right to a hearing, but that occurs at the second level. You first have to finish the appeal with the plan itself.

And then there has been legislation proposed. The Chronic Care Act includes a provision that would direct the Secretary of HHS to unify appeals and grievances to the extent possible for services provided under dual eligible special needs plans no later than April 1 of 2020. That legislation passed the Senate last year, and if it was to be enacted, it would affect contracts starting in 2021.

COMMISSIONER BURWELL: [Speaking off microphone.]

MS. BLOM: That's right.

So this is what the process looks like under current law. You can see the two, Medicare and Medicaid, next to each other are a little bit different. Medicare has more levels, and because it's a federal program, it does not include a state court review.

The first level is the same. As I said, after promulgation of the final Medicaid managed care rules, that everything starts with a health plan, a state fair hearing Medicaid doesn't occur until the second level.

A beneficiary -- well, I was going to talk about

expedited appeals, but I've already mentioned that.

On the Medicare side, if the health plan's decision is unfavorable to the beneficiary, then it automatically gets forwarded to the second level. This is important because this is one of the provisions that New York has adopted, so that the second level is like an independent review of the health plan's decision.

And then through each of these levels, the beneficiary typically has about 60 days to appeal to the next level. So, for example, when the beneficiary gets a decision from the ALJ, that they can then move to the next level as long as they filed that appeal within 60 days.

So key differences between the two, these are sort of the main sticking points. Amount in controversy, we discussed already, but that's basically just that there is a financial threshold that has to be met in order for the appeal to move forward.

The right to an in-person fair hearing is a Medicaid provision. The right to a hearing still exists, but it can only occur at the second level. But the in-person aspect of it can be potentially burdensome for beneficiaries, especially those who are disabled or have

difficulties with transportation.

We do understand that there is a high rate of default associated with these in-person hearings, and a lot of time, beneficiaries aren't able to appear.

In Medicare, the hearing occurs by video conference or telephone. There is an in-person option, but more typically, it's done either through video conference or telephone, which might be more manageable and might also serve to speed up the process.

And then, finally, continuation of benefits, which I've also mentioned, this is also called "aid paid pending" in Medicaid. This is a Medicaid provision only. It's established in regulations and allows the beneficiary to continue receiving their benefits while their appeal is being processed. This provision does not exist in Medicare. Medicare benefits cease during the appeal.

So we looked at several differences. States, as I said, are taking steps to address this. I want to focus on New York in particular because New York is the first state to develop a fully integrated process, so they've created a single process that all beneficiaries in their Financial Alignment Initiative move through.

In designing this process, New York really focused on what was most favorable to the beneficiary. They pulled provisions from each program that they identified as being more favorable.

So, for example, they adopted the continuation of benefits provision for Medicaid. They eliminated Medicare's amounts in controversy, and they allowed hearings to occur by telephone. Again, this was done under the Financial Alignment Initiative, which is done under a waver authority. So waver authority is what made possible this high level of integration.

MedPAC has sponsored several site visits to the demonstrations and invited me to join them, and on the last one, which was to New York, we heard a lot of support for the appeals process specifically. We heard that from everyone, from beneficiaries, from state folks, from health plans. It seemed like there was a lot of success there with this particular process, though that doesn't mean that this process would work everywhere.

So just quickly, to look at the way the appeals process works in New York, there's only four levels. It starts with the health plan, just like under Medicare and

Medicaid today. A second level of review is an independent review. This is an entity that was created for New York specifically. It then goes to the Medicare Appeals Council and ultimately to judicial review.

The timelines in here are the same. They're on 60 days, as they are on Medicare, and they did adopt Medicare's auto-forward provision. If the health plan decision is not favorable to the bene, the case is automatically forwarded to the second level. The beneficiary doesn't have to initiate that.

Other states have made efforts to align these processes as well. They haven't achieved the levels that New York did, but they have done things at the health plan level in particular to make it easier for the beneficiary and try to make the health plan level kind of like an integrated level.

A lot of that can be done outside of a waiver, and I think that's why states have sort of set out in that direction.

Minnesota, their senior health options program streamlines the appeals at that level. A health plan in California sort of does -- has the health plan do a lot of

the heavy lifting, so it decides for the bene which program the appeals should go through and uses the criteria of what's most favorable to the bene to make that decision.

And then within the duals demos, other states have integrated at the health plan level, and they've done things like use integrated appeals rights notices so that a person only gets one notice rather than two, one for each program. So, at the health plan level, there are efforts going on right now to streamline.

So I'd love to hear your feedback. We're just starting our work in this area, so any interest you have, any particular questions, it would be great to hear.

A couple that I have listed here include looking at evidence of improved bene experience or reduced administrative burden. With a lot of things in Medicaid especially, we don't have a lot of data on this. We don't really have data, a baseline data on what appeals are like now, but we have heard in New York and from others that the bene experience is improved. It is a lot easier, and it does seem like there's a certain level of satisfaction with a more integrated process, so we can look in -- dig into that a little bit more.

And then possibly think about the question of whether alignment at the health plan level is a good -- a pretty good first step. A fully integrated process, like what New York has, required waiver authority, and changes could be made to statute to allow all states to do that, but an easier, a lighter lift might be to look at what could be done at the health plan level across all states.

So, again, I'd love to hear feedback, and with that, I'm happy to take any questions.

CHAIR THOMPSON: Thank you, Kirstin.

Start off with Kit.

COMMISSIONER GORTON: So thanks, Kirstin. Good work, as always.

Just a couple of comments, just so that we have a common understanding. In your Slide 8, some states do offer the independent external review prior to the state fair hearing. In some states, it's optional, and the member can choose it. In other states, it's an automatic referral. So step two is not always a state fair hearing in the Medicaid program, although the beneficiary until this rule always had the option to go directly there if they wanted to go there.

Another nuance -- but it’s a nuanced business -- adverse findings by state fair hearing, there's a second appeal path in most states where they're subject to reconsideration by the Secretary or whoever is the relevant authority under state law, so just worth knowing for people who care about those details.

The second thing that I would say, before I get to this issue of using the plan as the integrator is on the next slide. You talked about the burdens on beneficiaries of an in-person fair hearing. Many states will allow the beneficiary to request a telephonic hearing, but the health plans have to show up. And that means -- and often that means that the health plans have medical leadership, who spend a good part of their time prepping for state fair hearings. So it's hugely administratively burdensome to the clinical operations of the health plan.

And one of the things that happens is the health plan shows up, and then the bene doesn't show up. And that's just a huge waste of time, energy, and effort, and so we're flagging whether -- and something we might look into, is there a way that somebody has figured out to deal with that. Certainly, in every state I've ever operated a

health plan in, that has been a major problem.

With respect to -- so I have two questions. One, with respect to New York, do we know -- and if we don't, can we find out -- whether this, what will seem to many people to be minor administrative piece, will be subject to evaluation under the program, so the waiver, so we can find out whether this works? Is it better? Is it a better member experience? Is it a better plan experience? Does it save any money, or is this just something that's being tried and then we will five years later not have any data about whether it's better or not? So that's one of my questions.

And then my second question is the states you've listed -- Minnesota, California -- they're not the first states to try and use the health plan as the integrating layer, and I wonder whether you know about the broader experience and whether that's something that we can look at.

My personal experience, running a Financial Alignment Initiative program for several years, is that it's comfortable for everybody, that the plan pulls the curtain, and the sausage making goes on behind the curtain.

It's a mess behind the curtain. You don't know which -- the benefit packages overlap. The payment limits overlap. The rights overlap. And your denial, the plans have to send two sets of denials. They have to send a Medicare denial, and they have to send a Medicaid denial. And so even at that point, even if you say, "Okay. Health plan, you do this," I would be interested in knowing -- and if you know, maybe you can share today, and if not, maybe in the future. Has anybody ever done this in a way which -- you know, it's a marginal improvement, and we should use it if it's all we got, but is it really anything close to a solution to the problem would be my question.

MS. BLOM: So on your first question about whether appeals would be part of the evaluation, my understanding is that the answer to that is yes for the demos.

I'm not sure that that's going to show us things like we had this many appeals before and now we have this many, but I think it is part of the plan for the evaluation, I guess I could say.

COMMISSIONER GORTON: So maybe we can dig into this a little more. Are the resolutions more timely? Does

the outcome differ in this approach? Are there more denials overturned in the integrated approach than there would have been otherwise? Is there better beneficiary experience in this process than the traditional route or with using the health plan as the integrator?

So I think if those questions are being asked, then it will be interesting to see the answers. If those questions are not being asked, then maybe we can ask people why and get some sense of will we come out with anything actionable in other places at the end of it.

MS. BLOM: In terms of your second question about the broader applicability or the -- I'm not sure. I think that there is definitely more research we could do in that area to look into that and to come up with kind of a broader perspective on what states have been doing in that.

COMMISSIONER GORTON: I think that would be useful. I think there -- because this is -- the intersection between Medicare and Medicaid is so thorny and difficult, I think there will be some who will want to say, well, just let the plan -- I mean, this is what was said in Massachusetts, "We'll just let the plans be the integrated, and it will be fine." And that certainly hasn't been the

experience in Massachusetts, and I suspect it won't be the experience anywhere else.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: Thank you for this information. This was one of many areas that we were struggling with and trying to better integrate services between Medicare and Medicaid, and it's one that we didn't have a great successful conclusion on.

What I was interested in, and this is part of the reason why, is because everything needed to change on the Medicaid side but Medicare was unwilling to make any changes on their side, which really made it complicated, to try to figure out how to integrate something when one of the entities wasn't willing to help with that process. But it sounds like, as I suspected would be the case, over time, things have evolved.

You said that in the case of New York that this aid paid pending requirement that was on the Medicare side -- oh, it was on the Medicaid side, so that's what I was -- okay. Because I was like, I'm still trying to figure out how Medicare altered their process in a single market to make -- you know, to make the appeals process different

there, because that always seemed to be the struggle, because of the way Medicare is set up. It's not necessarily conducive to changes market to market.

MS. BLOM: Yeah. They did adopt -- New York did adopt Medicaid's aid paid pending, so that everyone -- now Medicaid and Medicare benefits continue during appeal. Right. Right.

CHAIR THOMPSON: Kit.

COMMISSIONER GORTON: Just another point, another nuance that may be important to people. You're not integrating two appeals processes. You're integrating three. Medicare Part D has its own separate process, and they have been particularly resistant to anything in terms of changing their rules. So I believe, what I read from your materials, is that this is just about Part A/B and --

MS. BLOM: Yeah, that's right. Part D is excluded.

CHAIR THOMPSON: This is one of those areas where I just feel like it's been this perpetual conversation over a very long period of time, so it seems right that we're in it and talking about it. There's -- and I don't have like a great idea about exactly where we should be going here.

I mean, but there's one aspect of this, which is sometimes I feel like we're trying to integrate two kludgy processes, and what we really should be doing is a redesign, entirely, from the ground up, that really thinks about if you're a beneficiary -- I mean, I just think even the integrated process, for a beneficiary, is very difficult to navigate. It's very difficult to understand. There are lots of people who drop through the cracks. The plans still have their issues on their side to kind of sort things through, and that's if you spend two or three years figuring out how to make this work.

And I just wonder whether that's where our efforts should be, versus talking about, you know, is there a way to think about -- appeals are very important. You know, we just earlier got done talking about, you know, managed care and how do you create the capacities and the competencies to really address people's issues, and having these safety valves is very, very important. And when they don't work, you know, there's some, you know, recent clips about, you know, Iowa that don't paint a great story about that experience for beneficiaries.

But even under the best of circumstances, these

are not easy processes. Beneficiaries need help, they need advocates. I think we need to maybe talk with that community more directly about what it would look like to have a process that really tried to meet them where they are, was culturally, linguistically competent and response to them, and, you know, really had an objective and independent view brought into the process to ensure that they're being protected. And I just wonder whether our time is better spent identifying those key elements of models for people to think about, rather than to think about accepting the current process and then trying to figure out the integration points.

So we've got Brian was up first, then Darin, then Marsha.

COMMISSIONER BURWELL: I just have a question. So to what extent do you think the New York solution is a New York-specific solution or is it a solution that is easily replicated in the other demonstration states, and do you know if CMS has offered that as a potential solution in the other demonstration states?

MS. BLOM: My understanding is that other states didn't necessarily pursue that level of integration in the

demo. I'm not sure exactly why. I think that New York feels like they got in with CMS on this like right from the start and wanted -- and knew in advance this was something they wanted to do as part of their demonstration. So they had kind of the right people in place and already had a little bit of a plan to, you know, share with CMS. I'm not sure that that was the case with other states. It's hard to say.

COMMISSIONER BURWELL: You would think that if New York came up with a solution to a problem that is being experienced by other states that they would be interested in it.

MS. BLOM: I mean, it might also have to do with timing, if those things sort of weren't ready to go in the other states at the beginning. You know, the demos have been extended now several times, but initially they weren't planned to last this long.

In terms of whether this will work in other states, I think it could. You know, I think it would need to occur under a waiver to be done exactly the way that New York did it, but it potentially could work elsewhere.

COMMISSIONER BURWELL: And I assume we have not

made any decision about where we want to go with this, in terms of publications or anything.

MS. BLOM: No.

COMMISSIONER BURWELL: This could be a brief. It could be a chapter. We could do further research.

MS. BLOM: Yes. Yes.

COMMISSIONER BURWELL: Okay.

COMMISSIONER GORDON: You were saying two processes. Kit was pointing out there's probably three, and I'd tell you, Medicaid states, their process around appeal are all over the board as well. So, you know, the transferability, whatever New York did, yeah, you have to factor that into it as well. And states, you know, I used to ask states how many people that they had, you know, in their bureaus dedicated to appeals, and, you know, it's all over the board because their processes are different.

And so carving out just for your duals and making a modification of your appeals process, particularly -- and we had about 90 to 100 staff focused just on appeals -- and carving out a whole new process just for that complicates things. So it does get very, very complicated, and I think understanding this broader than just the New York situation

would help us understand the transferability of that kind of solution.

But I agree with you, Penny. I feel we struggle so hard to try to make two things that are clunky, at best, fit together and think that all of a sudden it's going to function with great, you know, a great degree of excellence as opposed to thinking, you know, let's back away from this and look at what are the components of a strong, ideal appeals process that people could adopt.

CHAIR THOMPSON: Marsha.

VICE CHAIR GOLD: Yeah. I did some work looking at plan reactions, or as the financial alignment demonstration was going on, and I second what other people said. You know, this is a real pain in the neck for everybody and it was a concern at the beginning.

My understanding, if I'm remembering right, is that back then, I mean, CMS -- the office -- the duals office was trying to get these things aligned under the demonstration. The template, they just threw Medicare and Medicaid together and they didn't have time to look at it.

I think it would be worth looking back a little at, since then, I mean, what happened nationally with the

effort to get them more aligned -- I see, in your longer write-up, that there was something proposed but it was very limited. I don't think it was left to the states to each work it out. CMS was going to. I gather it was hard to get Medicare to play, although I'm sure there's blame on every side. It's complex.

But it would be worth looking at a little bit more what happened. Maybe is the environment different now? Is there an ability under a new administration to restart some of that national discussion a little better, and just figure out what's solvable, nationally, what's one off, what isn't one off, and how -- you know, sort of looking at it more broadly.

And this is just one of maybe five areas where the regulations overlap, right? I mean, there were a number of areas where each program regulated it, and they regulated it differently, and it was a real mess, and when they did it originally, they just slapped the two requirements together, and no one thought that was a good solution.

And so looking at it, I think -- you looked at Minnesota, too, didn't you, because Minnesota has done -- I

mean, they did it way before there was a financial alignment demonstration and then they had to stop doing it because they wouldn't let them, and they let them do it again. I mean, maybe it's just Minnesota-specific, but they also had some experience.

Anyway, I second the value of looking at and the frustration of trying to do this. But in some ways, we're not going to get Medicare and Medicaid to be able to function for duals if we can't do these kinds of things. I mean, it has to align around the beneficiary and around whichever plan or state or whoever is going to be responsible for overseeing this stuff.

CHAIR THOMPSON: Toby. Do you want to jump in?

COMMISSIONER DOUGLAS: Just a fine point. On this aid pending, we've got to remember it's a financial issue and in the case of the -- you know, one reason why other states didn't is it's taking out of the rates to the -- on the -- to the dual demo plans, and, you know, New York made that decision to do that. But, you know, unless -- there are going to need to be -- you have to look at it from the sense of who is paying for these additional costs, if you're going to do aid paid pending.

CHAIR THOMPSON: So, Kirstin, it sounds like we have a lot of interest in the topic. I think there's some question about how much we want -- I think we need to spend time on the integration issue, because that's obviously, as Marsha has said, a key element to successful delivery of services to duals, is having a process that works for them for appeals.

But I think it would be interesting to kind of pull out into this larger question of what makes a good appeals process a good beneficiary experience. It's always a little difficult with something like appeals to talk about beneficiary experience, because it can't be predicated on a particular answer in the process, right, and obviously people who have a successful appeal tend to be more satisfied than people who don't.

But being able to access the process, understanding it, feeling heard, even if the result isn't what you want, is something that we're trying to aim towards, as a balanced and objective appeals process. And so we should think about whether or not there's some work that we could be doing to kind of understand what it's really like for beneficiaries to try to move through these

kinds of processes, and what they face in trying to do that, and whether or not there's some general models or approaches that, regardless of what we do from a procedural standpoint between Medicare and Medicaid, as an example, that we want to promote.

CHAIR THOMPSON: Okay. We will open it up for public comment now, if there are any -- all right, Camille. We are in conversation with Camille.

PUBLIC COMMENT

* MS. DOBSON: I promise that you do not see me when you're talking about DSH payments or --

[Laughter.]

MS. DOBSON: -- children's issues and stuff like that.

Just a couple of comments about the MFP Report to Congress. I mean, I couldn't agree more with all the duals issues, but having been at CMS when the alignment demos came up, the duals office just threw up their hands in frustration because they couldn't get anywhere. On the template, I helped on the Medicaid side and Medicare was just absolutely resistant. So moving on.

So about the MFP demonstration. Obviously our

members, the state aging and disability agencies, very much support an extension of the MFP, and I'm unclear about whether that's on your plate, to make a recommendation or not. But we have continuously vigorously advocated, both in the Senate and the House, to have it extended, and that's for a couple of reason. One, you know, we're dealing with the most -- exactly what Chuck said about once people are in, really even for 60 days, the supports that they have in the community start to fall apart. And so states haven't had the resources to be able to go in and try and do the heavy lift, and MFP, even without the enhanced match, the flexibility to provide those services was really helpful.

What we hear from our state members is that it's -- having MFP go away is a disadvantage for the fee for service state, because they're putting these responsibilities for transition coordination, and housing supports, and whatever on their health plans, and in MLTSS states, there's nowhere for those services to go without the enhanced funding, and the states may or may not be able to, you know -- Medicaid directors in this room know what the balance is about where you allocate resources. And so

I think they're worried that the transition coordinators and the housing coordinators that they hire with the MFP money, without that additional match, they might have to make different decision, whereas the MLTSS states have just pushed that to their plans.

And then the third piece, I think is important. Commissioner -- Leanna mentioned about the benefit -- of being able to provide the HCBS services while people are in an institution. That is a huge barrier. There's nothing you can do outside of demonstration funding to address the fact that you can't provide -- you can't get Medicaid match for those services while people are still in a nursing home. It was -- you know, there's still, nationally, 60 percent of people, older adults and people with disabilities, are in nursing homes, and dealing with nursing home transitions is one of the hardest -- again, I'm not saying anything that the Medicaid directors here don't already know, about how hard it is to address the nursing home industry in the state. And every person out is one less bed, which is a financial issue. So having the additional program support behind a state, sort of federally sanctioned, to some degree, to actually attack

the transitioning, has been helpful for states.

So I'll leave that.

CHAIR THOMPSON: Thank you.

COMMISSIONER BURWELL: Can I ask questions of the public?

CHAIR THOMPSON: Of course. Absolutely.

MS. DOBSON: Really? Okay, Brian. Bring it on.

COMMISSIONER BURWELL: Hey, it's just payback.

MS. DOBSON: Okay. Sure.

COMMISSIONER BURWELL: Has NASUAD, as a member organization, consolidated -- given a written response to the Report to Congress?

MS. DOBSON: We have.

COMMISSIONER BURWELL: To the administration or to Congress, or both?

MS. DOBSON: Not to the report. We sent something to CMS, echoing some of your comments about --

COMMISSIONER BURWELL: And that's a public document?

MS. DOBSON: No.

COMMISSIONER BURWELL: Oh, okay.

MS. DOBSON: Oh, you wouldn't want to see some of

our public -- our conversation -- our letters to CMS, necessarily. But we have commented on the fact that it was not -- that they didn't add anything much to the MPR, even though I know there's -- I mean, we talk with the CMS staff a lot, about how they're transitioning the states that are doing MFP to their waiver programs. So like that goes away -- what happens now? Do all the services -- can those services be rolled into their waiver? Well, in some cases they can, some cases they can't.

So we've been running up against the sustainability issue about moving those services and those payments into their (c) waivers. In some cases it's possible and in some cases states were very creative, and there's no way that some of what they paid for under MFP could be matchable, as a service, in a waiver.

COMMISSIONER BURWELL: Second question is, do you have a sense of where this sits in Congress now, an extension?

MS. DOBSON: You know, we've heard that there's some interest in the Senate, for sure, but it's getting crowded off the calendar, I think. We've briefed the Senate staff, both minority and majority, regularly. Our

states have gone in to talk to them. Much more receptivity in the Senate than we've had in the House right now. So we expected it to get put into a health bill, like the Chronic Care Act, maybe, or -- but so far there hasn't been a vehicle to attach it.

CHAIR THOMPSON: Thank you, and, of course, we invite you to submit any thoughts to us in writing, if you'd like to do that, to consider as we draft our comment letter, and as we consider how to position ourselves to be in the best position to advise the Congress on this matter going forward.

Okay. Wonderful. Thank you, Commissioners. Thank you to the public. Thank you, staff. Great two-day meeting. Thank you very much. We are adjourned.

* [Whereas, at 11:24 a.m., the meeting was adjourned.]