PUBLIC MEETING

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

Thursday, January 24, 2019
9:31 a.m.

COMMISSIONERS PRESENT:

PENNY THOMPSON, MPA, Chair
STACEY LAMPKIN, FSA, MAAA, MPA, Vice Chair
MELANIE BELLA, MBA
BRIAN BURWELL
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CHRISTOPHER GORTON, MD, MHSA
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ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:31 a.m.]

CHAIR THOMPSON: Okay. I think we are at time, so let's go ahead and get started.

We have an exciting morning in front of us, where we're going to bring some of our ongoing and long-time discussions on DSH and UPL to a close, at least in terms of agreeing on a set of recommendations.

Just for both the Commission and the public, we'll be clear about how we're going to go about this. Rob is going to provide a review of the chapter and the recommendations. There will be Commissioner conversation. We'll take public comment.

If Commissioners have changes that they would like to see in the actual wording of recommendations, the staff will take that back, and then we will revisit those revisions in the afternoon. If there are no revisions to the actual wording, we may simply move to a vote. That will be the case for both our conversation on DSH and our conversation on UPL.

We will pause before any final decisions to take public comment on both of those subjects.

Okay. So, Rob, go ahead and kick us off, and we'll start with DSH.

REVIEW OF DRAFT MARCH CHAPTER AND RECOMMENDATIONS: IMPROVING THE STRUCTURE OF DISPROPORTIONATE SHARE HOSPITAL ALLOTMENT REDUCTIONS

* MR. NELB: Great. Thanks, Penny.

So we have two hospital payment presentations today, and we're going to start with DSH. I'll begin by reviewing a draft chapter for our March report that describes the Commission's analyses of DSH allotments, and then I'll review the specific draft recommendations themselves and provide you some information about how these recommendations have changed based on your feedback at the December meeting.

Finally, we'll conclude by briefly talking about next steps for our work on DSH, including a preview of a session that we're planning tomorrow about the DSH definition of Medicaid shortfall.

So the report chapter begins by providing some background about DSH allotments and the historical variation of DSH funding by state. As you know, DSH

allotments vary widely by state based on state DSH spending in 1992, and they have no meaningful relationship to levels of hospital uncompensated care or any other measure of need.

The chapter also discusses DSH allotment reductions, which are added by the ACA under the assumption that increased coverage would reduce hospital uncompensated care costs. These reductions were initially scheduled to take effect in 2014, but they have been delayed several times. Under current law, allotments are scheduled to be reduced by $4 billion in FY 2020 and $8 billion a year in fiscal years 2021 through 2025, an amount that is more than half of states' unreduced allotment amounts.

Under current law, there are no reductions scheduled for FY 2026 and subsequent years, and so in those years, allotments are scheduled to return to their higher unreduced amounts.

Because DSH allotments appear unlikely to be further delayed, the Commission has been analyzing a number of approaches to restructure available DSH funding without increasing federal DSH spending.

Of course, the Commission has previously

expressed concern about the potential effects of DSH cuts on providers that are particularly reliant on DSH funding, but for the purposes of these analyses, we have limited our approach to looking at policies that are budget neutral to the federal government. And so we're not commenting about the size of reductions themselves.

In this work, we outline several policy goals to guide Commissioner consideration. First, we aim to improve the relationship between DSH allotments and measures related to hospital uncompensated care costs because, as I mentioned, to help correct some of this historical variation in state DSH funding.

Second, we aim to apply reductions to states independent of state policy choices, such as whether or not to expand Medicaid.

Finally, in order to minimize disruption for states and providers, we aim to phase in changes in an orderly way.

So the draft chapter concludes by discussing the state effects of the proposed policy relative to current law. As I mentioned before, again, the total amount of cuts are the same as under current law, but the effects on

states vary based on the methodology that we're proposing.

I'll discuss some of the specific findings later, but for now I just want to highlight that we talk about the effects of state DSH cuts, in terms of DSH funding as well as the effect on total Medicare hospital payments.

Based on your feedback at the December meeting, we included a more extended discussion about whether or not states will be able to offset the effects of DSH cuts by increasing other types of Medicaid payments to hospitals.

I also want to note that in order to calculate some of the state-by-state effects, we had to make a number of assumptions about how rebasing might be applied. If different parameters were used, this would change the effects of reductions on particular states.

So now let's take a closer look at the proposed recommendation package and the supporting rationale. Overall, we still have three recommendations that we anticipate that the Commission would vote for together as one package. These recommendations are largely the same as what we presented in December, since most Commissioners expressed support for the proposed recommendations at that time.

However, we did make some changes based on Commissioner feedback, including adding more description about the Commission's decision-making process, additional clarification about the data used for the geographic cost adjustment, and additional information about how reductions to unspent DSH funds would be applied. The memo in your materials highlights some of these specific changes.

Great. So let's dive into the recommendations themselves. The first draft recommendation reads as follows: In order to phase in DSH allotment reductions more gradually, without increasing federal spending, Congress should revise Section 1923 of the Social Security Act to change the schedule of DSH allotment reductions to $2 billion in FY 2020, $4 billion in FY 2021, $6 billion in FY 2022, and $8 billion a year in FY 2023 through 2029.

This recommendation is intended to mitigate disruption for DSH hospitals and provide time for states to adjust their other Medicaid hospital payment policies if they so choose.

The specific amounts proposed are intended to match the level of spending assumed under current law; however, CBO isn't able to provide a specific point

estimate for the recommendation since we're not recommending specific legislative language.

Ultimately, based on CBO's final estimate of any proposed legislation, the specific reduction amounts could be further calibrated in order to minimize changes in federal spending.

The second recommendation reads as follows: In order to minimize the effects of DSH allotment reductions on hospitals that currently receive DSH payments, Congress should revise Section 1923 of the Social Security Act to require the Secretary of HHS to apply reductions to state DSH allotments that are projected to be unspent before applying reductions to other states.

The intent of this recommendation is to minimize the amount of reductions to funds that are currently paid to providers. In FY 2016, about $1.2 billion in DSH allotments were unspent, an amount that has been relatively consistent over the past several years. By applying reductions to unspent funds first, this minimizes the amount of reductions that are applied to states that spend their full DSH allotment.

Here, it's important to note that the

recommendation is calling for a change in the methodology used to distribute reductions rather than a change to the amount of reductions in statute for a given year.

And last but not least, Recommendation 3 reads as follows: In order to reduce the wide variation in state DSH allotments based on historical DSH spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the HHS to develop a methodology to distribute reductions in a way that gradually improves the relationship between DSH allotments and the number of non-elderly, low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas. That is a mouthful.

As you know, we've had a lot of discussion about this recommendation, specifically about what measures would be best to use to base the allotments on.

So, first, based on our prior analyses, the Commission decided that the measures that were in CMS's existing allotment formula were not good measures to use since they weren't related to hospital uncompensated care and did little to rebalance the historical variation in DSH allotments.

Second, we considered basing allotments on levels of uncompensated care as defined on Medicare cost reports or DSH audits, but we found that these measures weren't very reliable, and so we ultimately ended up taking a closer look at three measures that are proxy measures that are related to the number of individuals in the state that are likely to have uncompensated care costs.

We looked at three different measures: the number of uninsured individuals; the number of Medicaid enrollees and uninsured individuals in a state; and third, the number of non-elderly, low-income individuals, defined as those under age 65 with family incomes less than 200 percent of the federal poverty level.

Ultimately, the Commission concluded that the number of non-elderly, low-income individuals in the state was the best measure to use since this measure relates to hospital uncompensated care costs and is independent of state policy choices.

As I mentioned before, the other measures that we considered either weren't reliable or they were highly affected by state policy choices.

It's important to note that basing allotments on

the number of non-elderly low-income individuals doesn't affect the fact that state DSH payments to providers are still based on actual hospital uncompensated care costs, defined as unpaid costs of care for the uninsured and Medicaid shortfall.

Also, nothing in this recommendation changes the measures that states can use to determine how they distribute DSH funding within their own state.

A few other points to mention include the fact that we adjusted the number of non-elderly, low-income individuals based on a statewide composite of the Medicare wage index in order to account for geographic variations in hospital costs.

And, lastly, we're proposing to phase in the changes gradually in order to provide states and hospitals with time to respond before the full amount of DSH reductions takes effect.

For each recommendation, the chapter reviews the estimated impact of the policy on the federal government, states, providers, and enrollees.

Even though we had intended for our policy to be budget-neutral, CBO ultimately estimates that the overall

recommendation is projected to reduce federal spending by between 1- to $5 billion over 10 years.

As I mentioned before, some of those savings could be potentially used to re-calibrate the reduction amounts or used for other purposes.

To look at the state effects, we compared reductions under the proposed policy to current law. So, as I mentioned before, the total amount of reductions is the same, but some states are winners and losers.

Specifically, under the proposed policy, there are larger reductions for states that have unspent DSH funds and smaller reductions for states with low DSH allotments per low-income individuals relative to CMS's current methodology.

The effects on providers and enrollees are a little more difficult to project. They'll vary by state based on the changes in state DSH allotments, but they'll also vary by how states respond to the DSH reductions.

In theory, some states may be able to offset reductions by increasing other types of Medicaid payments to providers, but in practice, we know that this is sometimes hard to do, especially in states that rely on

providers to finance the non-federal share of Medicaid payments.

So that concludes my presentation for today. Our plan is to include this chapter and recommendations in the Commission's March report along with the Commission's required analyses of DSH allotments, which you reviewed in October.

As Anne and Penny mentioned, we have time on the calendar later today for you to vote on these recommendations, but if you're comfortable with the recommendations as written, you can also vote on them during this session.

And then just a preview for tomorrow, in December you had expressed interest in learning more about recent changes to the DSH definition of Medicaid shortfall. This issue doesn't affect DSH allotments to states, and so we're considering it as a separate issue tomorrow morning.

Thanks.

CHAIR THOMPSON: Okay. Let me just ask one question, and then I'm going to go to Darin to kick us off.

Can you pull up Recommendation 3? I don't know if this is something about how this sentence is composed,

which is a very long sentence, or something that is more substantive.

But we talk about a methodology to distribute reductions. Can you, Rob, expand on this point a little bit? Are we understanding what we're doing here when we talk about distributing reductions? Because what we're really talking about is trying to get to the basic allotment approach about how DSH is allotted among states. So can you say a little bit more? And maybe that will lead us to suggestions about wordsmithing, but maybe not, depending on your answer.

MR. NELB: Sure. Yes, you're right that the Commission did decide to take a sort of broader view of looking at allotments more broadly and how to improve this relationship between DSH allotments and measures of need.

Specifically, in terms of the parts of the statute we're thinking of changing, there is currently certain factors that CMS is required to implement when it implements DSH allotment reductions, and so presumably that section of the statute would change, and so that's sort of what I was trying to get at, sort of outlining particular factors there.

As you note, maybe we need some other language that reflects the sort of broader goal that we're aiming for.

CHAIR THOMPSON: That helps me understand why we're couching it in this way in terms of reductions as it relates to Section 1923, but I'll put it out for Commissioners if there's some suggestions about that or whether or not that's just a matter for ensuring that we're clear in the chapter about the overall aim and the overall impact in terms of what we're doing with different DSH dollars.

Darin.

COMMISSIONER GORDON: Thank you for all the work on this. It's been very, very, very helpful.

A couple question that you maybe can shed some more light on. First of all, when it relates to taking unused DSH dollars, I think there's probably a multitude of factors that relate to having unused DSH dollars, and what caught my eye is I saw where like in Tennessee, for example, where there was showing that there was 3 percent unused DSH dollars, which was perplexing to me because I obviously know what the formula was and how that worked in

that there was sufficient uncompensated care, and there was sufficient funding for it.

So it made me wonder what all is caught up into why a state may show that they have unused DSH dollars.

MR. NELB: Sure. First all, we're projecting unspent DSH funds using data for the past three years that is in CMS's budget and expenditures system.

So states have up to two years to spend money from a particular allotment, and then after those two years, we looked to see whether they spent it or not.

In general, most states have unspent DSH funds for one of two reasons. One, they didn't have the non-federal share to draw down the DSH payments, or two, the DSH funding is actually larger than the total amount of uncompensated care in the state. So even if the state sort of maxed our DSH payments to every hospital, it still couldn't spend its full DSH allotment because there's not enough uncompensated care in the state.

I think the particular example you raised around Tennessee might be a case around where maybe the state thought there was enough uncompensated care for a particular hospital, but when the uncompensated care was

audited, maybe some funds got taken back or something. So that's a consideration, I suppose, as you think about the different data sources that are used. We're looking at it after the year has closed out, which is after the audits and other things happen.

COMMISSIONER GORDON: Yeah. And I think that's the likely issue there in Tennessee, which makes me believe this could be the case in other states as well.

I like that particular recommendation. I just think that the data source is going to be really, really important for states who have historically had unspent money, and they're just not doing it because there has historically been no additional uncompensated care beyond what they have been spending or they didn't have the match. That seems very logical to me.

I do worry. If you think about it in the case when the audit started going, that has an effect on hospitals' attention to making sure that the data they're providing the state to be tighter, and so you may not see that same dynamic in the future years that they have something as a result of an audit that they weren't able to reallocate back out to hospitals.

So I think that's a different circumstance when I think about it than those who are just year after year just not touching considerable sums of money, and I believe, just from what I know from over 22 years of this, that there are some states that that is the case. And it's probably the lion's share of the unspent DSH funds, but that's just one thing to note.

I do like the first and second recommendation, with the second one having that little caveat that the data source is really, really important there.

I do have an issue, which I have stated at prior Commission meetings, with the third, not that I think it is -- not to say that I think that using 1992 as a basis for DSH funding is the great solution -- or that that's the perfect answer. I think there is probably room for improvement there.

As I think about it, even like our lead into the chapter talking about DSH being statutorily required payments and intended to offset hospitals' uncompensated care costs for Medicaid and uninsured patients and to support the financial stability of the safety net hospitals, I do believe the uninsured rate, which does have

a strong correlation to uncompensated care, that is something I think that is fundamental and not having that there. And I get it.

In your description, there were the other ones we looked at, either didn't have good data sources or they were strongly affected by state policy decisions. This one is there is good data sources. It is strongly correlated. It's just really strongly influenced by state, state policy decisions, and I get that. But I also believe the whole reason where you had the discussions about reductions was on the premise that more people would be covered, again, all back to uninsured. For that not to be there just feels like too much of a departure for me.

But, again, I really appreciate the first two recommendations. That third one, while I think is directionally an improvement, I still prefer the uninsured over that, but appreciate your.....

CHAIR THOMPSON: You know, I appreciate the way in which you recognize the pros and cons of each one of those sides. The only comment that I would make to what you just said, Darin, is that there was an assumption that state coverage decisions would be consistent across the

Nation. I mean, that was the other element of the idea here, and so I think that's another complication for thinking about how to then take these reductions when that wasn't the case.

COMMISSIONER GORDON: Yeah, and, you know, my history here goes a little further back than the ACA. When we did this in Tennessee -- and I don't think we had the right answer then because we said, you know, we thought there would be no uncompensated care, so we did away with our DSH allotment altogether, which in hindsight was a terrible idea and not factually accurate when more information was gained. Massachusetts, unfortunately, did some things smarter than us, but they learned the same lesson, and I think the ACA learned from both of those situations, saying that there's still going to be uncompensated care, but because there should be less -- more coverage in the individual market or Medicaid, that that would warrant some change here. And I agree that it was contemplated to be broader, but, still, I think the underlying premise is the same.

CHAIR THOMPSON: Other comments from the Commissioners? Chuck.

COMMISSIONER MILLIGAN: Great work, Rob. I align myself with Darin. I do think the uninsured to me belongs in the recommendation. I do think that we have to recognize that the Sebelius decision happened, and I do think that we have to recognize that state policy choices matter here. So I think we need to reflect uninsured in this recommendation, personally.

CHAIR THOMPSON: I guess the question is we discussed this at an earlier commission meeting and tried to hash out where the Commissioners might be and kind of weighed those two different approaches -- right? -- recognizing that that might mean some Commissioners may not support the recommendations and others might. So I'll open it up for the Commission in terms of coming back to that conversation as opposed to settling on a language of the recommendation that reflects the prior conversations.

COMMISSIONER MILLIGAN: If you don't mind, if I can kind of jump first.

CHAIR THOMPSON: Yeah.

COMMISSIONER MILLIGAN: And my apologies for not having been present at the December meeting. If the recommendation was in the form it is right now, I would

still vote in support. I think it's an improvement, and I think it reflects the charge we've been given to, you know, provide neutral, nonpartisan, analytic kind of recommendations to Congress.

But I think it would be improved with reflecting the uninsured, and maybe just to elaborate a minute about this. The reductions are part of the ACA. The ACA was premised on an assumption at the time it was passed that all states would do the Medicaid expansion. The Sebelius decision after that changed that requirement for states. And so I look at a couple of different factors that I think to me the best interests of the program and DSH is best reflected by reflecting uninsured.

One, the states that, per Sebelius, had the right not to do the Medicaid expansion have more burden, presumably, in their safety net hospitals, and I think the data shows that in terms of just uncompensated care. And so I do think that to me providing the support underlying the DSH policy around the state right not to have expanded and the hospitals in that state having a higher burden of uncompensated care, I think that that is kind of factually accurate.

Taxpayers in those states are federal taxpayers. They are paying for the Medicaid expansion even if their state elected not to do the Medicaid expansion. And so if that state has a higher rate of uncompensated care and if that state needs to fill the gap in uncompensated care through a non-DSH approach, the taxpayers in that state are then also shoring up the safety net hospitals through a variety of different kinds of funding mechanisms.

I do think that to me it's inconsistent to say this was mandated by the ACA and we shouldn't take into account state policy choices, while at the same time not recognizing that the Sebelius decision, which influences greatly the burden of uncompensated care in states and at state safety net hospitals, gave states the right to make policy choices here.

So I do think that state policy choices and the implications to the uninsured, to the safety net hospitals in those states that -- I mean, the hospitals didn't make the choice about whether to expand or not. I do think that that uninsured correlates to the need, and I think it's inconsistent not to recognize the Sebelius decision in this discussion personally. So that's kind of my own view.

As I said, I would vote in support of this in spite of that, but I think it would be improved with that.

CHAIR THOMPSON: Thank you.

Alan and then Melanie.

COMMISSIONER WEIL: I didn't think I'd come after two people who were speaking in opposition to the 1.3, so I think maybe I'll start with where I was going to go and then try to respond to what was said.

I did feel, as I read the recommendations, that although we as a group have not decided to take a position against the reductions, that we don't -- that having a recommendation for how to do the reductions is almost more supportive of the reductions than I would like us to come across, even though I don't think we want to have a statement against. And I actually think -- I say this with some trepidation -- I may have a fairly uncontroversial edit to Draft Recommendation 1.1, which is just to begin it with the phrase, "If Congress chooses to proceed with the DSH reductions currently in statute," comma, so that we're saying if you're not going to change the law about doing the reductions, this is how we think we should do it, as opposed to we think you should do the reductions, which

without context could seem as preferring. So that's my start --

CHAIR THOMPSON: Can I ask one question about that?

COMMISSIONER WEIL: Of course.

CHAIR THOMPSON: So would that apply to all three, or would it apply to one and two but -- I mean, coming back to the conversation on the third, regardless of how we deal with the methodological question, we still couch it in terms of reductions. Would we say, "If, Congress, you weren't doing reductions, then we would be satisfied with not improving the relationship" --

COMMISSIONER WEIL: Yeah, so I -- I don't want us to burden everything. Here is my take on it. It's a very good question. I don't think it's necessary for 1.2 because it says to minimize the effects. I guess I feel like it's sort of a preamble to all three, and so I don't feel like it would have to be restated all three times.

I think it's an open question whether in 1.3 we think the DSH allocations as a general matter should be modified even if there were no statutory requirement to do reductions.

CHAIR THOMPSON: Right, right.

COMMISSIONER WEIL: I kind of don't want to -- I mean, I'm not -- my goal here was not to open Pandora's Box.

CHAIR THOMPSON: Yeah, okay.

COMMISSIONER WEIL: And so I was --

CHAIR THOMPSON: Okay.

COMMISSIONER WEIL: If we can do it without opening Pandora's Box, I'd like to say it. If it opens, then I withdraw my --

CHAIR THOMPSON: So your revision for the moment would be --

COMMISSIONER WEIL: Would just be 1.1

CHAIR THOMPSON: -- just with respect to 1.1.

COMMISSIONER WEIL: Just 1.1.

CHAIR THOMPSON: Okay.

COMMISSIONER WEIL: But let me just, since I have the microphone, state my support for Recommendation 1.3 as written without really any disagreement with what either Darin or Chuck had said. I just think there is one factor that's missing, which is this is a capped program, not an unlimited entitlement. And, therefore, even though under

the Sebelius decision states are perfectly within their rights to not adopt the Medicaid expansion, if we include the consequences of that in a formula for reductions in a capped program, there are spillover effects to states that chose to expand Medicaid based on decisions by states that chose not to. And I don't think that that's an appropriate spillover to recognize. So it's not to criticize the state for its decision or to even disagree with the notion that the need may be higher, but in a world of -- it's not just a world of limited resources. It's in a program by statute defined to have a limited pool. The moment you say we're just going to account for those states' decisions, you're having a negative effect on others.

And I would just put this in contrast to general rules around rates and coverage where, because there is no cap, you can happily look at one state's decision and it has no effect on other states other than the overall size of Medicaid spending, which might put pressure on the program. But to me that's the defining feature that makes -- although I think everything you say true, makes me end up saying we should -- that other states should not have their allocations reduced because of some states'

decisions.

CHAIR THOMPSON: And I do think that was part of the texture of the conversation last time as well. It's interesting to also contemplate how that plays out when we think about, you know, a future conversation on Medicaid shortfall, for example, and decisions that play into the creation of Medicaid shortfall and whether those get encouraged or discouraged or how they get recognized in some of these systems.

Melanie?

COMMISSIONER BELLA: Yeah, thank you, Rob. Alan said what I was hoping to say more eloquently, but I guess what I'm struggling with is the concept of -- and, Chuck, it goes to your point. These cuts came, as Penny said, under the premise that all states would have done an expansion. And so it seems inconsistent to me to take individual policy choices into account when the premise of the cuts was that there wouldn't be state policy choices. And so I'm not following that part of the logic. And it's not necessarily that I need to follow that part of the logic, but I actually see it in the reverse of how you see it in terms of if the cuts were premised on all states

doing the same thing, we shouldn't then be taking into account state individual decisions because we feel like that is somehow what Congress -- because that wasn't Congress' congressional intent certainly when these cuts were passed.

So I don't disagree that there's value in the uninsured. I guess I feel much more comfortable with looking at it as proposed in Recommendation 3.

CHAIR THOMPSON: I'll let Chuck jump in if you want to. I will say that when we had the conversation last time, we talked about correlations and, you know, I don't know, Rob, if you have those data handy, but it was this question of what's correlated with need and nothing is -- no measure is perfect, first of all, right? That was one conclusion that we came to. And the other was that the non-elderly low-income population was pretty well correlated, almost as well correlated as uninsured, but without some of the friction of getting into the question of how states are making different decisions and what incentivizes or disincentivizes. Have I correctly characterized kind of --

MR. NELB: Yes, I think that's right.

CHAIR THOMPSON: Okay.

MR. NELB: They're all moderately correlated. No one's perfect. I think the number of non-elderly low-income is actually better correlated with the uncompensated care reported on DSH audits, which includes Medicaid shortfall as well as unpaid cost of care for the uninsured. And so as you'll recall, even though we found that states that expand Medicaid had a decrease in unpaid costs of care for the uninsured, they've actually had a pretty large increase in Medicaid shortfall. And, actually, we found for the DSH hospitals that actually there was a net increase in uncompensated care even in those expansion states in '14. But, yeah, so moderate correlation, but it also depends a little on how you define uncompensated care.

CHAIR THOMPSON: Yeah. But let me just let Chuck, if he -- Chuck, did you want to jump in?

COMMISSIONER MILLIGAN: Yeah. I don't want to take too much air time because I know others -- I guess just one quick thing about Alan. I agree with -- I mean, I see your point, and I think there's a lot of thoughtfulness to all of the points. I do think there already is a spillover effect because taxpayers in Texas are funding the

expansions in other states. There is a spillover effect once you get below the state policy level to who's funding the Medicaid expansion, and it is spilling over, and yet -- and so the taxpayers in the states that didn't expand, if they're asked then to carry the lift for uncompensated care, it comes in the form of often county taxes -- other kinds of things.

And, Melanie, I see the comment you're making, and forgive me if this is just me being confused. I would have preferred every state expanding Medicaid. I mean, I would have preferred that kind of the ACA as created would have been, you know, a state expansion of Medicaid everywhere. But if a state under Sebelius has the right not to do that, to me there is more need to serve people who are uninsured in those states, and I do think that is correlated in the data. So I do think that it's to me incongruous to say the DSH should just truck along as if everybody expanded because that was the policy objective in the ACA and not recognize that states could choose not to do that. And I think it does create a disproportionate burden, so to speak.

But, again, I don't want to bog us down because,

as written, I would support it. I just think to me it would be improved.

CHAIR THOMPSON: Anne, you wanted to, in the context of this part of the conversation --

EXECUTIVE DIRECTOR SCHWARTZ: Yeah.

CHAIR THOMPSON: -- draw attention to --

EXECUTIVE DIRECTOR SCHWARTZ: I just wanted to draw your attention -- and I'm sorry for the public that we don't have this on a slide. It's on page 19 of the draft chapter, Figure 1.3. This shows the state-by-state effect under the full recommendation. And I think what's interesting about this is, first of all, it shows the large group of states who have the smallest reductions. But in every single one of those buckets of the level of which they'll be affected, it is a mix of expansion and non-expansion states. So just to clarify that. And when we talk with Hill staff, they are aware that there's a pending food fight, but it won't be along the expansion/non-expansion lines.

CHAIR THOMPSON: Okay. I have Fred, I have Darin, Toby. Go ahead, Darin, if you want to, on this subject.

COMMISSIONER GORDON: Just on the correlation, just so I'm interpreting Table 1.1 correctly, there's great correlation on number of uninsured individuals as it relates to total uncompensated care reported on the Medicare cost reports than number of non-elderly low-income individuals. And it is -- and what you were emphasizing earlier was it was a tight -- they're all but similar when it relates to correlation uncompensated care for deemed DSH hospitals reported on DSH audits.

MR. NELB: Yeah, and as a reminder, Medicare cost reports just report uncompensated care for the uninsured, so Medicaid shortfall is not part of that other definition.

CHAIR THOMPSON: Toby and then Fred.

COMMISSIONER DOUGLAS: Anne and I were on the same page literally and figuratively. I think it's important, really, that this has no impact -- or no disproportionate impact on one group or the other, that this isn't about the Sebelius, and that's a really important point.

CHAIR THOMPSON: Fred.

COMMISSIONER CERISE: Yeah, I'm going to make a quick comment about 1.3 and then a couple other comments,

but I've stated my position on 1.3 before. I'm prepared to vote for the recommendation, sort of in Chuck's position. I do think the correlation is strong with uninsured, at least based on Table 1.1. And if you're looking for that correlation, it's inherently in conflict with the second principle, and that is, applying reductions independent of states' decisions, so there's going to be some give and take there. And either one is certainly better than the 1992 method of distribution. And so I am prepared to go along with the recommendation.

A couple of other things. Darin mentioned the unspent DSH dollars. That did concern me as well, just sort of where that -- why that is. I know in Texas, for instance, they held back some DSH distributions to deal with some potential -- the potential lawsuit related to the third-party payment for dual eligibles. And so I think we have to be careful there in terms of how you apply that and see what states -- if they're not drawing their DSH dollars, it may not because they don't have the state share or they don't have the cost, but there's some intentionality to that. And I think it's something to be careful about as we get specific in a rule there -- not in

a rule, but as something gets applied.

And then I just wonder about the CBO savings and the $1 TO $5 billion in savings that you kind of mentioned that you could recalibrate the reductions. And I wonder if we shouldn't be just more explicit about, you know, it's not our intent to generate those rather than just mention that they could be a sign -- say that we think they should be a sign to limit the reductions.

CHAIR THOMPSON: Bill.

COMMISSIONER SCANLON: I just wanted to comment, because in the first meeting when we discussed this I was actually sort of in the position that I thought that the uninsured was the primary measure, and I felt that there was a lot of sentiment for sort of using the broader measure of low income. And I came to accept that, in part, because the correlation was sort of intermediate and the issue of sort of data problems. But, I mean, I do think, conceptually, it is the right measure.

And to go to Alan's point about sort of the fact that this is a program with a fixed amount of money, to me that's actually a compelling reason why it's the right measure, because I want the dollars to go to the

individuals that are most in need. And so their distribution -- I mean, forget about sort of transfers between states -- their distribution is reflected, in my mind, most strongly, sort of in the counts of in the uninsured.

And, yes, there are Medicaid shortfalls -- I'll accept that -- but I think, at the same time, I really worry more about sort of the people without insurance that are being sort of served by these providers.

And I don't want to sort of undermine the strength of our recommendation for 1.3. This idea of starting a reallocation of DSH dollars that's more reflective of genuine need I think is incredibly important. It's both an issue of what we've been talking about today, which are the population measures. To me, the cost adjustment is also a major change in how we think about how dollars should be spread across the country and that, sort of, I think, is also very important.

The last thing, to Fred's point, I respect CBO incredibly and also think that they have an impossible job. When you look at our recommendation and it says the Secretary shall develop a methodology, if you asked me to

make an estimate I would probably be saying, "And what exactly is the Secretary going to come up with as that methodology?" you know, because I think that there is this -- and maybe it's reflected in the range of the estimate, you know, $1 to $5 billion. It's very hard -- it's hard to be very precise about sort of any kind of an estimate. Having some language in our narrative that we are in favor of this being budget neutral, I would certainly support that too.

CHAIR THOMPSON: Stacey.

VICE CHAIR LAMPKIN: And I'll try to be brief. I know we're towards the end of time.

I just wanted to express support as written, but also recall us back to the meeting in -- and I think it was more than one meeting ago, where we really spent time hashing this discussion of metrics out.

So we're hearing a lot of voices today about uninsured, and I'm going to say something about that too. But when we had that more thorough discussion, there was much more preponderance of preference for the low-income, non-elderly metric, which is why we continued down that path. So even though all those folks may not be

reiterating their support today, I would call our discussion.

The thing that I wanted to say about -- and again, I do support it as written and recognize that this is a metric that is the preference of the broader set of Commissioners. My own preference for uninsured, though, was a little bit different, so I just want to bring that back out, get it on the record, and then we can move away from it. And I think it comes with the challenge of having to take a very large, integrated, complex hospital payment system in pieces, even though we do have a broader look. And having to work with where we are right now, knowing that other recommendations we make related to other pieces of it may change the dynamic here a little bit.

And so, for me, I'm specifically talking about transparency and being able to track and know what we're paying for what we get and paying for a little bit of Medicaid over here, from this pot, and a little bit of Medicaid hospital over there, and a little bit of shortfall over here makes it really difficult for us to know what we're paying hospitals and being able to measure that for what we're getting.

So consider the definition of uncompensated care, including Medicaid shortfall, is the world that we live in today. It may not always be the world that we want to live in, and so we may lose that correlation and connection with our desired uncompensated care metric.

Down the road, that was my preference for uninsured more than -- although I hear what Chuck and saying, and all the other good arguments. And that's all I wanted to say. Thank you.

CHAIR THOMPSON: Before I open it up for public comment, I want to come back and see if there's any other Commissioners who share my concerns about the way in which we are describing 1.3, or 3.1. What is it?

EXECUTIVE DIRECTOR SCHWARTZ: 1.3.

CHAIR THOMPSON: 1.3, which is characterizing it as distribution reductions. In our discussion, we talked about the fact that it's kind of a rebasing along with a distribution of reductions that we're suggesting, and there are some hospitals that would actually end up with increases in some of the scenarios where we talked about some of the design considerations.

So I just worry that there is a way of

misinterpreting the scope of what we're recommending with this recommendation when we characterize it in terms of just distributing reductions. I don't know what the right answer is to that, or I just want to throw it out for the Commissioners to see if others share those concerns and maybe want to see some language that at least talks about distributing reductions and adjusting something, so that we -- I understand you want to tether it to 1923 and to the reductions, but we are talking about something broader than that.

Bill.

COMMISSIONER SCANLON: I have an edit that I think would do it, which would be to say methodology to distribute the reduction, and that refers to --

CHAIR THOMPSON: Globally.

COMMISSIONER SCANLON: Right. That refers to the aggregate --

CHAIR THOMPSON: Globally.

COMMISSIONER SCANLON: -- and then the issue is this redistribution --

CHAIR THOMPSON: Uh-huh.

COMMISSIONER SCANLON: -- redistribution of that

aggregate could involve plusses and minuses.

CHAIR THOMPSON: Yeah. That could work, I think.

Toby?

COMMISSIONER DOUGLAS: I was just going to -- why not just take out, to develop a methodology in a way that gradually improves. Why do we even need to say?

MR. NELB: Yeah. We can work on the words. I think it could be distribute allotments or something.

CHAIR THOMPSON: Yeah.

COMMISSIONER SCANLON: But that is even broader. That's, I think, the concern that you're raising, which is are we talking about the full $12 billion or are we talking about these incremental changes?

COMMISSIONER DOUGLAS: Well, I thought, it's the whole -- I mean, it's the whole DSH -- it's not -- it's the whole formula. So in 1.3 we're changing more than just the reduction.

COMMISSIONER SCANLON: If I understand the chapter, we're only moving around these amounts of dollars in a given year. Is that correct, or not?

CHAIR THOMPSON: So, Rob, can you jump --

COMMISSIONER SCANLON: Yeah.

CHAIR THOMPSON: -- jump in?

MR. NELB: Yeah, sure. So in some ways we are -- the methodology to distribute the allotments but we're using the reductions as sort of the basis for doing that. So we're doing -- you know, for those states that have really high DSH allotments per low-income individual they're getting those reductions first, and that's sort of -- we're doing that piece. There is a small part where, over the long term there would be some small increases for states with low DSH allotments per low-income individual, so you could argue whether that's part of the reductions or not. But, you know, it's, in general, the, you know, this is a -- we've been working with those $8 billion and how to distribute the funds that are left over after you have those cuts.

CHAIR THOMPSON: Okay, yeah.

COMMISSIONER BELLA: So now I'm confused. So what are we doing after 2026? What happens after 2026?

MR. NELB: Sure.

COMMISSIONER BELLA: 2029. Sorry, 2029. No.

MR. NELB: Right.

COMMISSIONER BELLA: Yes, in our -- yeah, yeah,

yeah.

MR. NELB: Yeah. So maybe it's actually best, what happens after 2023, so we get to the full $8 billion in cuts, and then there are $8 billion in cuts for 2023 through 2029. So in those years, DSH funding for states are mostly the same, but there is a portion that would have otherwise been applied as an inflation-based increase for -- the inflation amount for a state's reduced allotment amount. And that portion goes, over time, to help raise up some of those states with low DSH allotment per low-income individual.

So a state would continue to have its allotment and that allotment would increase based on inflation, just like it has in the past, but the portion of the allotment that was reduced, the small inflation-based increase of that would go to a state that has a lower allotment per low-income individuals.

So, basically, by 2023, you know, we've narrowed a lot of the variation among states. Over time, there will be some minor incremental improvements to further minimize the variation. But most of the changes happen in those first four years when the cuts are taking effect.

CHAIR THOMPSON: Martha.

COMMISSIONER CARTER: So my understanding is that Recommendation 3 pretty much takes us a leap past just talking about the reductions but a recommendation that actually rebases how DSH payments happen.

MR. NELB: Yeah, I think that's fair to say that over the long term, you know, the Commission's goal was to improve that relationship between DSH allotments and the measures of need, and so we are getting there over time, but in an incremental, gradual way.

CHAIR THOMPSON: And with the reductions kind of leading the way there --

MR. NELB: Yes. That is --

CHAIR THOMPSON: -- as opposed to kind of stepping back and saying, okay, well let's just redo DSH according to a different approach, and redistribute it, and then take reductions, right?

So, Rob, what's your reaction to the idea of -- obviously, you wrote it as to develop a methodology to distribute reductions, so you must be happy with that, right? But do you think with this conversation there needs to be some clarification? What would be your suggestion to

the Commission that we could think about in terms of either a revision of the language, or maybe it's just a matter of clarifying this in the kind of subsequent text?

MR. NELB: Yeah. I think we can definitely clarify it in the text and add to that. If you did want to tweak the language, you know, again, maybe you could say methodology to distribute allotments or something a bit broader. But, you know, we can think about some specific language if you want.

I think this -- as I mentioned in the beginning, the -- I used the language "distribute reductions" because I -- just like from the statute, I imagine that this would get sort of -- it would replace the part of the statute that currently describes the existing reduction methodology. And so that's sort of the -- sort of how it could be interpreted. But, you know, we're not drafting specific legislative language and so maybe we want to be more open-ended and Congress can figure out exactly where in the statute it fits.

CHAIR THOMPSON: But we're thinking that their approach to this is about how they direct the Secretary about reductions, not going to the part of the statute that

is specific about how do you calculate what your DSH allotment is, or do we care?

EXECUTIVE DIRECTOR SCHWARTZ: That's right.

MR. NELB: Yeah. I mean --

CHAIR THOMPSON: We're -- we think of it as the former, not the latter, and that's how we modeled it.

MR. NELB: Yeah, although ultimately we're presenting what the final allotment is for the state, you know. And I guess, yeah, whether you -- so that -- we model it as what the new reduction amount is and then we subtract it off of the state's unreduced allotment amount. But, you know, what matters at the end of the day is what the final allotment amount is, and I guess you could get at it in different ways.

EXECUTIVE DIRECTOR SCHWARTZ: Can I just add, our starting point was without endorsement or enthusiasm for the current law, that the reductions are going to take place. Our starting point was: is there a way to think about how those cuts take effect in a way that achieves these other policy goals. So that's why we started there.

I feel like I am sometimes a broken record. The recommendation lives within a broader context: the chapter

which describes our intent and goal. The recommendation is a specific change to somebody to do something, and so that's why we went in this place.

So, that should describe that rationale for the wording.

CHAIR THOMPSON: Yeah. Okay. Okay. Toby.

COMMISSIONER DOUGLAS: Yeah. I'm sorry. I'm confused now, so I apologize.

So if you take a state's allotment at the end, is the methodology a combination of the old methodology of using uninsured and the new methodology, or is it all based now on the low-income?

MR. NELB: So, remember, the old methodology is based on what you spent in 1992 --

COMMISSIONER DOUGLAS: Yeah, okay.

MR. NELB: -- increased for inflation. We calculate what the reduced allotment amount is by figuring out sort of the difference between where a state is now and where a state would be if the allotments were fully rebased, and then we have sort of a phase-in to incrementally implement some of those changes. So --

CHAIR THOMPSON: But we don't -- so this is very

small. So we establish kind of a target based on a different methodology and we apply -- we say we need to get towards that methodology. We're not suggesting that Congress change the statute to that methodology, right? We're setting a model and we're moving the reductions, and some adjustments --

MR. NELB: Yeah.

CHAIR THOMPSON: -- in a way that gets us closer to that point. So there may be a time at which, after these reductions take place, that you would want to actually then, if you were happy kind of with your progress, change that methodology, right, so that that becomes the new methodology, that now people are closer to, and you could, at that future point in time, adopt a new approach without as much disruption, right? Is that an accurate way to describe this?

MR. NELB: Yes, I think so. And, yeah, because, again, we also remember that the allotments, even under our recommendation, would only go in -- reductions only go until 2029 --

CHAIR THOMPSON: Yeah.

MR. NELB: -- so technically --

CHAIR THOMPSON: Yeah.

MR. NELB: -- in 2030, the allotments return to their higher --

CHAIR THOMPSON: Right. Okay.

MR. NELB: -- unreduced amount. And so if Congress then wanted to extend it, they would --

CHAIR THOMPSON: Okay.

MR. NELB: -- be saving those different things.

COMMISSIONER DOUGLAS: So it is accurate to say reductions.

CHAIR THOMPSON: So it is accurate to say reductions, but we need to make it clear in the text.

MR. NELB: Yeah.

CHAIR THOMPSON: And this is where I think that we need to emphasize the point that regardless of the fact that different Commissioners may have different preferences about non-elderly, low-income, or uninsured, there is universal agreement that either one of those is preferable to 1992.

MR. NELB: Yeah.

CHAIR THOMPSON: And so that's where we're aiming, and we can bring out some of the conversations that

have happened between the Commissioners about different methodologies. I do want to reinforce Stacey's point that, you know, I appreciate a number of people bringing up the issue that they prefer a little bit of a different phrasing here with regard to the methodology or approach, but I do want, when we come back to vote this afternoon, for people to speak to this point, because I want to be sure that we're not just assuming people's -- you know, sometimes that happens that those of us who would like to see a different wording or whatever are speaking up more where those of us who are satisfied with it aren't. So I want to be sure that we kind of collect that for the record, so that we accurately describe kind of where Commissioners are with respect to this.

But it seems to me, based on this conversation, that we can be happy with this wording, but we have to be really clear in the text about, you know, that we did kind of create a new model that we're aiming towards, and using the reductions to get us there, without necessarily changing the underlying allotment methodology globally.

EXECUTIVE DIRECTOR SCHWARTZ: And let me just add to that. I mean, the chapter is some number of pages and

there are many places where these nuances come out. But one of the things that we always do in each report, for each chapter, is there's a page of key points, which you haven't seen yet, because we wait until the very end to write that so we know what the key points are. But that is also a place for us to emphasize the thinking and the logic about it, not just what the recommendations are, and it's another place -- you know, it's the elevator speech about what we were trying to accomplish.

CHAIR THOMPSON: Yeah. Okay, Sheldon, and then I'm going to go to public comment.

COMMISSIONER RETCHIN: I just -- just a brief comment. This is very painful, and it's the end of a long odyssey, and I know, Rob, you'll find another mission in life.

[Laughter.]

COMMISSIONER RETCHIN: But just looking at, first of all, Figure 1.2. Rob, if you could just -- because Melanie had asked about what happens after 2029, and you just answered. But if I look at 2022, our extension, is the difference in the green-dotted or -dashed and the top for unreduced allotments, as we extend it out, is that

where the $1 to $5 billion in CBO savings comes from on the federal? Where does that come from?

MR. NELB: Sure. So the CBO savings you can't really see from this graph, in part because CBO doesn't assume that like a $1 billion in reductions equates to a $1 billion federal savings. There's a variety of pieces to CBO's formula. Of course, it actually assumes that states would offset some of the cuts by increasing other Medicaid payments --

COMMISSIONER RETCHIN: I see.

MR. NELB: -- and not all states spend this whole DSH allotment. So -- let's see -- so --

COMMISSIONER RETCHIN: But in the aggregate --

MR. NELB: Yeah.

COMMISSIONER RETCHIN: -- our reductions will generate, in the aggregate, larger reductions in the summed aggregate. If I look at the current law versus our recommendation, is that right?

MR. NELB: Yes, and then CBO, yeah, projects the $1 to $5 billion.

COMMISSIONER RETCHIN: Just now we have a longer tail that will -- just a point made. But I won't -- going

back there. A lot of moving parts.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah.

COMMISSIONER RETCHIN: We have the Sebelius decision that divided, made this optional. We had pre -- we had 1992 differences that had no -- and we're trying to move all this.

I originally came square on the current recommendation and I'll stay there, because there is no good. -- None of the suggested approaches really is a pure -- however, I will say I'm maybe just now maybe gathering a little more enthusiasm really for Alan's preamble. This is very painful.

Make no mistake that those expansion states, the safety net systems, that Medicaid shortfall is real, and in many cases safety net systems actually lost on the expansion. There wasn't a dollar-for-dollar substitution. And then the non-expansion states are still unheard.

So I just wanted to make that point.

CHAIR THOMPSON: Okay. Let me just pause and then, as usual, a great conversation, very rich, I think, in a lot of additional detail that helps us clarify some points in the text.

I only -- I think, in the end, we've only landed on one change to the recommendation language itself, which was Alan's suggestion in terms of the first recommendation, to make it clearer that we're -- you know, to the extent Congress decides to proceed, I think Alan had slightly better language that I'm assuming you wrote down, Rob.

But let me open it up for public comment, and even though we didn't have a lot of changes in the recommendations I'm going to push this to the afternoon, because I want to be sure we have ample time to take the vote, because I imagine that as we go around people may want to make commentary, in addition to proving a yes-no, and I want to make sure that we have sufficient time for that.

So -- but I do want to hear any public comment with respect to the recommendations and this discussion.

PUBLIC COMMENT

* MS. OFFNER: Good morning. My name is Molly Collins Offner. I'm the director for policy for the American Hospital Association. We submitted comments to the Commissioners yesterday with regard to the recommendations, so I won't go through the entire letter,

but I would like to sort of summarize the key points.

Before doing so, I just wanted to extend our appreciation for the very thoughtful examination that the Commissioners and the Commissioners' staff have undertaken to really delve into the Medicaid DSH program.

With that said, the two recommendations that we focused on in our communication yesterday really focused on Recommendation 1 and 3.

With regard to Recommendation 1, the AHA continues to urge Congress to delay the ACA DSH reductions until more substantial coverage gains are realized. And while we appreciate the efforts of the recommendation to mitigate the disruption by reducing the level of cut and extending it over a period of time, we still would prefer a delay to that implementation.

With regard to the restructuring, while we appreciate that this methodology is embedded in the methodology as it relates to the ACA reduction methodology, we are concerned that it's a departure from the statutory provisions and metrics that look at uncompensated care and Medicaid shortfall as it relates to hospitals. And we raise the following concerns that this is a departure and

would require opportunity for stakeholders to really be able to put forward concerns and issues as it would move through the legislative process. But we also raise concerns about quality of data and timeliness of data that's used to analyze any kind of change of this magnitude to the DSH program.

So that's our key highlights with regard to the recommendations, and thank you.

CHAIR THOMPSON: Thank you, and we did receive that communication. Much appreciated.

MS. GONTSCHAROW: Hi. Good morning. Zina Gontscharow with America's Essential Hospitals. Thank you for the opportunity to provide this public comment this morning, and we are very appreciative of all of the hard work that the Commission and its staff has done to date on the Medicaid DSH issue and appreciate the thoughtfulness around trying to mitigate the cuts.

We just wanted to reiterate and urge the Commission to really clearly communicate to Congress and other stakeholders the devastating impact of the reductions regardless of how it could or may be mitigated. We are talking at a certain point of gutting two-thirds of a vital

funding stream for essential hospitals, and that's just simply unsustainable.

And we also just wanted to reiterate that as the Commission continues to work on Medicaid DSH policy, to not lose sight of the importance of targeting DSH payments within a state, not just allotments across the states, and to ensure that DSH payments are truly being targeted to essential providers that are relied on by their vulnerable populations.

Thank you.

CHAIR THOMPSON: Thank you both.

Okay. I think we have a break on the schedule, so why don't we go ahead and -- is that right or no? Oh, no, we're moving on to UPL. Sorry. Rob, I was trying to give you a break, but no break for you.

[Laughter.]

CHAIR THOMPSON: Okay. Why don't we go ahead and move on to UPL.

REVIEW OF DRAFT RECOMMENDATIONS FOR MARCH REPORT: UPPER PAYMENT LIMIT COMPLIANCE

* MR. NELB: All right. Back for more. So now we're going to take a look at another set of proposed

recommendations related to upper payment limits for hospitals, known as the UPL.

In December, you reviewed a draft chapter that will accompany these recommendations in our March report, and so I'll just focus my presentation today on the recommendations themselves.

So you have the slides in your materials, so I can --

CHAIR THOMPSON: Yeah, but we do need them up for the public.

EXECUTIVE DIRECTOR SCHWARTZ: They have copies.

CHAIR THOMPSON: Oh, are there copies on -- okay.

EXECUTIVE DIRECTOR SCHWARTZ: Yes.

MR. NELB: The second one there. There you go.

So I will begin by recapping the Commission's discussion from the December meeting, review changes to the draft recommendation language, and then discuss the draft recommendation. Overall, we're proposing two recommendations that we anticipate the Commission would vote on together as one package.

So in December, you will recall that we reviewed the draft chapter summarizing our UPL analyses. The UPL,

as you'll recall, is an upper limit on fee-for-service payments to hospitals. It's based on a reasonable estimate of what Medicare would have paid for the same service. States can make UPL supplemental payments to hospitals based on the difference between base payments to hospitals and that amount that Medicare would have paid.

In our review of state UPL demonstrations, we found a number of large discrepancies between actual and reported spending. In particular, in 17 states we found that the actual amount of UPL payments made in state fiscal year 2016 appear to have exceeded the limit calculated on state UPL demonstrations by $2.2 billion in the aggregate.

We shared these findings with state officials and CMS but weren't able to fully explain some of the discrepancies. And we also learned during the process that the limits that are calculated on the state UPL demonstrations are not routinely used in the review of claimed expenditures, which might explain some of these big -- in other words, there's not really a process in place to reconcile some of these discrepancies that we observed.

In December, we had initially proposed that CMS establish a process to certify that UPL demonstration data

were accurate and complete, but based on Commissioner feedback, we modified the recommendation to broaden the discussion to discuss a range of process controls that could be implemented to ensure that spending is below the UPL. Certifying UPL demonstration data is one such process, but other process controls could be in place either before or after states submit their UPL demonstration data.

Also based on Commissioner feedback, we reviewed the tone of the chapter and tried to balance the concerns that were raised about MACPAC's finding with caution about the accuracy of the underlying data.

And so the first recommendation we have here reads as follows: The Secretary of HHS should establish process controls to ensure that annual hospital upper payment limit demonstration data are accurate and complete, and that the limits calculated with these data are used in the review of claimed expenditures.

The rationale for this recommendation begins with the underlying purpose of the UPL, which is to provide an upper limit on Medicaid payments to provider. If UPL limits are not being enforced when the payments are being

made, then they aren't achieving their purpose. Existing regulations already require state spending to be below the UPL, and these regulations already give CMS authority to defer federal funding that exceeds the UPL. However, we found that it's challenging for CMS to enforce these UPL requirements because the data that it collects are not reliable. As I mentioned, in the years that we looked at, we found examples of billions of dollars of payments that are missing and large discrepancies for the payment data that are available.

There are a variety of different process controls that CMS could implement to better enforce UPL compliance. However, as I mentioned, the Commission isn't recommending a specific process for CMS to follow.

The impact of this recommendation really depends on whether CMS continues to find evidence of UPL overpayments after reviewing more accurate and complete data. If so, CMS could recoup payments in excess of the UPL using its existing deferral process. However, CBO doesn't assume any federal budget savings from this proposal since it is merely intended to enforce existing policy.

Depending on how the policy is implemented, states and CMS may have more or less administrative costs. Currently, CMS estimates that the existing inpatient and outpatient UPL templates require about 80 hours of state staff time to complete per response.

Providers could be affected if it's found that they ended up receiving UPL payments in excess of the UPL. But the corresponding effect on enrollees will depend on how providers respond if their UPL payments end up being recouped.

The second recommendation reads as follows: To help inform the development of payment methods that promote efficiency and economy, the Secretary of HHS should make hospital upper payment limit demonstration data and methods publicly available in a standard format that enables analysis.

Since UPL payments are such a large part of Medicaid payments to hospitals, it's important to understand where this money is going. In FY2017, for example, UPL payments were actually larger than DSH payments to hospitals. But unlike DSH payments, which are audited annually, we don't have publicly available data

about how UPL payments were spent.

This recommendation builds on MACPAC's prior recommendations for more transparency in Medicaid payments to hospitals. While we would ultimately like to have complete data on all types of Medicaid payments, UPL demonstrations are an existing data source that can fill an important gap without creating a new reporting structure for states and CMS.

MACPAC's interest in these data is not only for transparency but also to help inform the development of payment policies that promote the statutory goals of efficiency and economy. For example, more complete data on UPL payments that states make can help inform analyses of whether these payments are well targeted and can help inform our understanding of how these payments relate to other types of Medicaid payments that hospitals receive.

The effects of the second recommendation are more limited since states are already providing UPL demonstration data to CMS. There may be some increased administrative burden required for CMS to post these reports publicly, but it's not expected to change federal spending.

So that concludes my presentation for today. Similar to the DSH allotment recommendations, we've reserved time at the end of the day where you can vote on these. However, if you don't have any changes to the recommendations, we can also vote on them now. Thanks.

CHAIR THOMPSON: Okay. I'm just going to kick off with a couple of comments and then turn it over to Kit for more.

I really like what you've done with the recommendations, and so let me just express appreciation for the responsiveness to the conversation that we had at the last meeting, which was, you know, to aim at the end instead of dictating kind of the interim steps that need to be taken in the process to achieve that.

I do think that, not with respect to the recommendations but with some of the discussion after the recommendations, we're -- I would like to see us be a little stronger in that language so that if we can put up especially the first recommendation -- can we get to that? I think there are some standards that we could tether this to, including the standards that are established under the CFO audit for the agency about financial controls and how

financial controls are determined to be adequate or not adequate. I think there are some things that we say, well, CMS could do this and CMS could do that. I think that maybe those should be listed as, you know, things that CMS should actively consider and evaluate with an aim of getting to this endpoint, because I think some of those steps are actually necessary to get to this endpoint that we say CMS could do.

So I'm very happy with how you've constructed the recommendations, and I just want to be sure that as we discuss the supporting rationale, you know, that we help CMS aim a little bit more towards understanding that they do not want to have a material weakness in their CFO audit, for example, and the steps that they will need to ensure that that does not occur.

Kit?

COMMISSIONER GORTON: So I'll second Penny's observation that I think you've done a marvelous job responding to at least my concerns from the last meeting. I think the new language for the drafts is now much more aligned with the picture you paint, and I do think that the balancing of the tone, which I demonstrated last time,

could send people into orbit. I think that's appropriate, and so that lines up well. So I'm pretty -- I'm completely comfortable with where you ended up with Recommendation 1, and I would support Penny's point of being a little more concrete in the narrative, and I'm great with the recommendation.

Recommendation 2, I just have -- and I'm not an editor or a wordsmith, so I'm not going to propose a specific change. But I believe you can read Recommendation 2 to say that Secretary of HHS should make hospital upper payment limit demonstration data available in the aggregate, and I don't think we want it in the aggregate. I think we want it specifically. And I wonder whether the recommendation should -- I don't know how to say that. I don't know what the right terms of art are. But I'm worried that somebody could say, well, you have that already --

CHAIR THOMPSON: Well, except UPL applies in the aggregate, so there is a certain amount of that. I think the answer will -- does CMS collect hospital-specific data under the UPL demonstrations?

MR. NELB: Yes.

CHAIR THOMPSON: They do? Okay.

MR. NELB: The existing hospital UPL demonstration data is hospital-specific.

CHAIR THOMPSON: Okay. Okay.

COMMISSIONER GORTON: So maybe just insert the word "specific" after "hospital." Yes?

CHAIR THOMPSON: Yeah.

COMMISSIONER GORTON: Anyway, those are my only two thoughts. But thank you for your great work as always.

CHAIR THOMPSON: I'm just contemplating that point. Are all of the UPL demonstrations inclusive of hospital-specific data?

MR. NELB: Yeah, so in terms of the data, it is supposed to be hospital-specific. I think as you talk about data and methods, you know, some of the methods are sort of more broad. There might be some narrative that goes along with it. You know, the hospital-specific data is then used to aggregate to what the overall --

CHAIR THOMPSON: Calculate the actual UPL.

MR. NELB: -- UPL is.

CHAIR THOMPSON: But what is that hospital-specific data?

MR. NELB: It includes information about the Medicaid payments and then that estimate of what Medicare would have paid in select --

CHAIR THOMPSON: Okay, okay.

MR. NELB: -- the hospital's costs or charges or different things.

CHAIR THOMPSON: Okay. So to take Kit's point about ensuring that the recommendation is not interpreted to --

EXECUTIVE DIRECTOR SCHWARTZ: I think if you put "hospital-specific" in there before data, it does not affect the word “methods”.

CHAIR THOMPSON: Yeah, okay.

EXECUTIVE DIRECTOR SCHWARTZ: I don't have a concern about that because there is no hospital-specific method.

CHAIR THOMPSON: Right, exactly. Okay. So hospital-specific upper payment limit demonstration data and methods. Okay. Melanie.

COMMISSIONER BELLA: Yeah, thank you, Rob. Penny, maybe my question goes to your point. Recommendation 1, so we want them to collect better data.

We say they don't have good data. And so we say go figure out how to get good data, and then let's make transparent that data. I mean, if we make -- right? So, I mean, I'm trying --

CHAIR THOMPSON: Well, sort of --

COMMISSIONER BELLA: -- to figure out, is Recommendation 1 actually getting at whatever is happening to not allow them to collect these data that we believe would allow us to see --

CHAIR THOMPSON: How I would characterize it, Melanie, is that I think what we've found is that they're collecting data; they're not applying it consistently in a process that allows them to ensure that expenditures are being made consistent with that information, but maybe part of the problem is that information is not correct, right? So we don't know -- there's a delta between those two data, the expenditures and the demonstrations. We don't know what accounts for that delta. So there's both the issue of using it and ensuring that it's accurate, which we're not taking as a given because it's possible that some of the delta is explained by timing, accuracy, other issues, you know, updating, et cetera, as opposed to, no, I'm really

out of compliance with my methodology and my intention.

So I think it's intended to capture kind of both those processes, which is we need to make sure it's accurate and up-to-date and actually used, and then we want it to be publicly available so that other people can use it as well to understand what's happening --

EXECUTIVE DIRECTOR SCHWARTZ: And we want it to connect to the claiming process, so that there are two separate processes happening completely independent of each other and the only one that really, really matters --

CHAIR THOMPSON: Right.

EXECUTIVE DIRECTOR SCHWARTZ: -- is the claiming process. And so maybe you don't have to pay so much attention to how accurate the UPL demo data are. The point is that if the two things connect, the data --

CHAIR THOMPSON: Yeah, but that's all in Recommendation 1, and I'm trying to make --

EXECUTIVE DIRECTOR SCHWARTZ: In Recommendation 1.

CHAIR THOMPSON: -- the connection between 1 and 2, which is what I think you were --

EXECUTIVE DIRECTOR SCHWARTZ: Right, but the

point is that 1 isn't solely focused on collection.

CHAIR THOMPSON: Correct.

EXECUTIVE DIRECTOR SCHWARTZ: It's on connection.

CHAIR THOMPSON: There is data collected. Whether it's accurate hasn't been tested. That's the issue, because it hasn't been used.

COMMISSIONER BELLA: I think what I'm just struggling with is CMS doesn't typically go about doing things in like an uninformed way, and so I'm trying to figure out like what has prevented them having this information and is our recommendation addressing the fact that they don't.

MR. NELB: So, yeah, I mean, to be -- even as we talk with CMS staff, they're very interested in trying to improve their processes, too, and have appreciated what we've done. This has been a new process for them, so there's been some hiccups along the way, I think, but, yeah, coming down to some of the timings or definitions and things, and then also just there's been -- there has never really been a process for CMS to give feedback on what the states submit, and so some of these problems sort of keep coming back up. But if we add this feedback loop in,

presumably it'll help start improving the data and make it more reliable for other purposes.

CHAIR THOMPSON: Okay. Any other comments on these recommendations?

[No response.]

CHAIR THOMPSON: Okay. We'll make the one change, and, again, we'll go ahead, given where we are with timing on the agenda, and put this over to the afternoon to take a vote and look forward to that.

Public comment on this part of our discussion this morning?

PUBLIC COMMENT

* MS. GONTSCHAROW: Good morning again. Zina Gontscharow with America's Essential Hospitals. Just really quick comments.

We appreciate all of your thoughtful work around the UPL payment policies. We know it's not easy. I just wanted to just make clear that we believe that MACPAC should really, really clearly communicate in this chapter and in the recommendations that this is the first attempt to really examine and analyze this data since CMS first began collecting it.

We appreciate Recommendation 2 talking about how this data should be made public because it is not at this point, and so no one else has really had a chance to weigh in on the findings in any detailed level.

It is also clear to us that more information from CMS and additional analysis is needed before we can make any concrete conclusions.

States are currently complying with multiple processes and review mechanisms before making these payments to providers, and we urge the Commission to make this clear in their report and in any recommendations to ensure that incorrect conclusions are not made about state estimates and the disbursements and providers' use of these payments.

We appreciate the opportunity to submit these comments and look forward to collaborating on this issue in the future. Thank you.

CHAIR THOMPSON: Thank you very much.

Okay. Rob, you're off the hook for now, but not for long. We'll see you tomorrow, right?

EXECUTIVE DIRECTOR SCHWARTZ: This afternoon.

CHAIR THOMPSON: Oh, this afternoon? Can't get

enough of Rob.

Okay. We are going to take a break and then come back and talk about program integrity. I'm going to go ahead -- it's 11 o'clock -- and give us our full 15-minute break, so we'll be back at 11:15 sharp. Thank you.

* [Recess.]

CHAIR THOMPSON: All right. I'm going to give everybody the 30-second warning.

[Pause.]

CHAIR THOMPSON: Okay. Jessica, anticipation has been rising because we were going to talk about this at our last meeting. We ran out of time. We wanted to be sure that we gave it high-energy attention, so thank you for being patient with us. And we're now eager for this conversation. So why don't you go ahead and kick us off.

MEASURING PERFORMANCE AND RETURN ON INVESTMENT FOR PROGRAM INTEGRITY STRATEGIES

* MS. MORRIS: Good morning. I was going to say I think Rob is a lefty. I must have shuffled everything over to the other side of the table here.

[Laughter.]

MS. MORRIS: A tough act to follow.

Good morning, Commissioners. In this presentation, I'll be summarizing the findings and potential next steps from a study looking at measuring the performance and return on investment in Medicaid program integrity.

Federal and state agencies pursue a variety of PI strategies to identify and address fraud, waste, and abuse, despite limited information about which generate the most value for the investment.

Some of these activities are embedded in the state's programmatic functions, while others are for the purposes of ensuring the public dollars are spent appropriately.

In the March 2012 report, MACPAC noted concerns about whether program integrity efforts were making efficient use of public resources. We recommended elimination of redundant and outdated programs and to determine which are most effective.

In 2017, we reiterated these recommendations in a chapter on program integrity in managed care. These recommendations are consistent with the Government Accountability Office's framework for managing fraud risk

in federal programs, which encourages managers to consider benefits and costs when investing in resources.

In 2018, we sought to learn more about which PI activities are most effective. We contracted with Myers and Stauffer to collect information from states and how they measure the performance and the return on investment from a number of approaches. We conducted an environmental scan to identify which approaches to examine our study. We reviewed CMS program integrity review reports, state and federal agency websites, oversight and annual reports, as well as relevant laws, regulations, and policy.

Then to learn more about these approaches, we interviewed CMS, subject-matter experts, and officials in eight states.

Return on investment is a ratio that measures gain or loss relative to an investment. PI activities in particular are measured by the return from cost recoveries and cost avoidance relative to the cost of the approach.

Quantifying ROI could help states identify and focus on high-value activities, given their constrained budgets.

It can be used to determine the efficiency of an

investment or to compare a number of investments. Investments may include staff costs, including legal staff, medical professionals, data analysts, as well as contractors or other tools, such as data analytics.

In your memo, I have provided additional detail on how cost recoveries and cost avoidance are calculated.

States perform a broad away of PI activities, from data mining claims for overpayments to performing background checks that screen for bad providers. We chose 10 approaches for this study based on a variety of factors, including the availability of information on the implementation and the operation of each approach within the state, documentation available on cost avoidance, cost recovery, or other ROI measures, and the majority of the approach.

In these next few slides, I will describe these, including how states measure the effectiveness of each approach.

Data mining is a PI approach that while not federally mandated, states may identify outliers and high-risk areas in payment data that can be used to audit specific providers.

Data mining can be measured in recoveries, such as with potential overutilization, or results may lead to cost avoidance, such as if the state implements policy changes that result in fewer improper claims.

Electronic visit verification as a PI approach is used to monitor the arrivals and departures of caregivers as they provide services in the beneficiary's home. States are required to implement an EVV program and ensure that services are billed as rendered.

As states are in varying stages of implementation, they may ultimately be able to calculate cost avoidance such as through claims denials.

Provider enrollment as a PI approach can identify questionable providers prior to being allowed to provide Medicaid services. States may conduct criminal background checks including fingerprinting, particularly if the provider is high risk. ROI may be calculated through cost avoidance from keeping good providers enrolled and bad providers out, thereby reducing unnecessary administrative costs. There's no standard methodology measuring the costs avoided from provider enrollment, and states often lack the resources to develop their own. States also report

recoveries when terminated providers pay a settlement fine.

RACs. Following success in several states, in 2002 CMS allowed states to contract with vendors to examine claims and collect recoveries from overpayments; TPL or credit balance collections, among other activities on a contingency-fee basis. In 2002, state Medicaid programs were required by statute to establish a RAC program. However, in recent years, several states obtained waivers of RAC program requirements, and I'll talk more about that in a minute.

CMS contracts with UPICs to perform PI audit activities. Ultimately, states may calculate ROI, but states have minimal quantifiable evidence for this new program date. States often perceived the CMS UPIC program as duplicative with the RAC program, but UPICs have a wider scope involving Medicare. They have regional assignments, greater access to data, and are paid on a cost-plus fee basis. Given their shared goals, it may be possible in the future to compare the ROI for WPICs in RAC programs.

Provider self-audits are performed by the provider either because the state asked them to or because the provider reported an issue that warranted further

investigation. In most cases, self-audits are initiated when the provider identifies inappropriately paid claims that do not involve concerns of fraud or abuse. States may calculate ROI from claims adjustments as well as cost avoidance from updating billing policies or provider education.

PARIS is a database that matches data from public assistance programs with other data by finding those that receive assistance in multiple states or through multiple programs such as Medicaid and Veteran Health Care. While all states are required to submit data to PARIS, they are not required to use the results. States may generate an ROI by avoiding cost from duplicate enrollment or overlapping services.

Lock-in programs assign a beneficiary to a single provider, such as a doctor or a pharmacy, in order to control utilization, monitor services, or curb drug-seeking behavior. Cost avoidance from decreases in unnecessary prescriptions or services may generate a return on investment.

Prior authorization. To varying degrees, states opt to conduct prior authorization for specific services

and prescriptions. Prior authorization policies may lead to cost avoidance through denied claims for unnecessary services. Recoveries can also occur through a retrospective review of paid claims.

TPL, third-party liability, and estate recovery are both required by statute. Because Medicaid is generally the payer of last resort, states must pursue recoveries from third-party payers, including private insurance, Medicare, worker's compensation, veterans' benefits, and court settlements. States are required to recover costs for providing care to those over the age of 55 from the beneficiary's estate once admitted to a facility or after death.

Compared to other state PI activities, it's often clear when calculating ROI because states are required to report significant TPL and a estate recovery cost avoidance on the CMS-64. Therefore, using CMS guidance, states must dedicate staff directly to working on these calculations.

The goal of this study was to determine the ROI of various PI efforts and to quantify which are most effective, and despite our efforts, we were unable to collect ROI for most PI strategies for a number of reasons

that I will highlight.

This supports prior MACPAC findings and shows earlier recommendations remain relevant, and while the study did not generate clear findings on the most effective program integrity efforts, we found states have had varying levels of success with different strategies.

And, finally, our research reveals several issues that may merit further consideration.

This study identified several challenges to gathering ROI information for the range of state PI activities. First, many states did not or could not calculate ROI. ROI is most easily calculated when there are clearly identifiable resources used to conduct the activity, and the results include state recoveries.

Thus, activities focused on recoveries from post-payment reviews were most likely to be used in ROI calculations. These include data mining resulting in provider audits, the RAC program, and TPL in the state recovery. Note that both RAC and TPL activities are federally mandated programs that will require reporting on the CMS-64.

Recoveries can be directly measured, but there

are different ways to measure cost avoidance making it difficult to formulate apples-to-apples comparisons.

For some, calculating cost avoidance is straightforward. For example, TPL cost avoidance is typically built directly into the claims adjudication system.

For other activities, there are no clear parameters for calculating cost avoidance in Medicare. Lock-in programs, for example, can be calculated by monitoring a period of avoided unnecessary claims. However, there's no consensus on the time period to include when accounting for costs avoided.

Furthermore, PI activities do not exist independently. For example, a single claim can be subjected to both prior authorization and third-party review. A provider investigation can lead to an overpayment recovery as well as termination. This makes it difficult to attribute costs or allocate recoveries to particular strategies.

We identified other limitations in calculating ROI. In many cases, when given the option to develop their own metrics, states may use performance measures that then

cannot be used for cross-state comparisons.

Also, certain PI activities, such as provider enrollment, are federally required. Therefore, a state may not want to invest resources and tracking the results or calculating the ROI because it will not change the state's decision on whether to continue that activity.

Lastly, states may not focus entirely on quantifiable benefits when choosing PI activities, such as when they address issues of abuse and neglect.

While the costs avoided from these activities can be difficult to quantify, the improvements in patient safety and health outcomes for beneficiaries do provide value. The process of prior authorization, for example, can help ensure beneficiaries receive only medically necessary services.

Finally, our research identified policy areas to improve the effectiveness and the efficiency of PI activities. The first opportunity focuses on managed care and PI. In June 2017, we reported on a survey of state PI activities in managed care. We noted that states have developed their own policies and procedures in PI, resulting in variation among states and what they require

of MCOs and how they conduct MCO oversight.

More recently, we learned many are still working to improve connections between fee-for-service and managed care. States reported that the return on certain PI activities was limited because managed care was excluded from the review or because encounter data was inaccurate or incomplete.

If managed care data are not available, post-payment reviews might not be able to detect potential fraud and abuse. CMS may want to consider two suggestions the Commission has made in June 2017 to provide additional guidance to states on MCO contracts, to provide states with more opportunities to learn from each other, such as encounter data validation methods.

The second opportunity pertains to the RAC program. By contracting with auditors to conduct post-payment reviews, states incentivize vendors to recover payments on their behalf. However, as I noted, RAC vendors work on a contingency, and some will not bid on RFPs for RAC programs unless potential recoveries will cover its costs.

The federal and state requirements often limit a

RAC's ability to be sustainable. For example, the state controls the full scope of work. Therefore, RAC vendors don't pick which areas will be reviewed.

The state makes the final decision on all collections, and after the RAC has invested resources, the state may make a settlement for a fraction of the results.

In recent years, many states have obtained RAC waivers from CMS. In fact, eight states have waivers due to procurement issues. Sixteen states have waivers due to low volume of fee-for-service claims.

Given these challenges and the number of states with waivers of the statutory requirements, should participation in the RAC program be optional for states?

This would be consistent with MACPAC's 2012 recommendation to ensure that PI efforts make efficient use of federal resources and do not place any undue burden on states.

Lastly, the federal Medicaid PI strategy is high level and focused on one-on-one state auditing and support. CMS noted challenges in providing guidance to states, given the differences among 51 state pricing policies and payment systems.

CMS could collect and compare the information states have and share the approaches that result in a return on investment. Still, states continue to seek guidance and methods that measure performance.

In closing, the recommendations MACPAC made in 2012 and 2017 remain relevant as states continue to pursue a variety of PI strategies, despite limited information about which generate the most value for their investment.

I look forward to a discussion of our findings and any potential next steps for this Commission on program integrity. If there is interest in making recommendations, such as those related to RACs or to reiterate past concerns, we'd appreciate your thoughts on the nature of these recommendations and any additional information that would help assist you in making such decisions.

As a reminder, if you want to make any recommendations, we will bring the Commission a decision-memo with proposed recommendations and a rationale for the March meeting and present a draft chapter at the April meeting for publication in June.

CHAIR THOMPSON: Thank you.

I'll jump in and open up our conversation. As

many people know, I've been involved in these issues for lots of time. I kind of started my federal career at the Office of Inspector General at HHS and grew up there, and at one time, I ran program integrity in CMS. I work with different companies today that try to provide program integrity solutions to states, including some that do TPL and RAC work. So I want to disclose that.

I'll start off with a few observations and then maybe a couple of suggestions.

I do think this issue of performance measurement and program integrity is really important, and its' been a long-time issue, and it's not just about Medicaid, where the measurements are easiest, as you mentioned, after you've made a payment and you collect it back.

Of course, to some extent, that incentivizes an activity that we should see as a failure, which is having made the payment in the first place. I think we need to think about this question of how we look at performance and also understand the costs, not just the costs associated with actually carrying out the program integrity activities, but also what kinds of issues and challenges, requirements, and responses and reviews place on

beneficiaries and providers. And I do think we need to think more holistically about that question.

The second is that I know that we kind of selected some things to look at here, and by the way, I think we should try to produce this in a chapter in June, put it together. I do think we ought to acknowledge some of the places where we don't have information or we didn't review.

One of the big areas for program integrity is claims processing and claims review, and we don't have that represented here.

We don't exactly have the SURS units represented here, although there is, as you mentioned, some overlap.

So I just think that we need to locate some of these activities and functions around eligibility in payment, and some of them are techniques and approaches, and some of them are contracting vehicles. So if we can kind of make sense of that into some graphic, I think that would be helpful for people to understand.

Up against some risk framework, as you mention, I think GAO has particularly been very astute about talking about you need to look at where your risks are and what

constitutes risks, and that ought to be driving where you make investments and how do you select approaches to respond to that.

I would like to see us grapple with that a little bit more in terms of where are Medicaid expenditures, where are vulnerabilities based on the characteristics of payments and expenditures and requirements, because I think that's something worth thinking about.

We don't mention PERM, the Payment Error Rate Measurement program. Again, there should be some nexus between some of these activities and PERM, or if we think PERM just does not provide enough information and feedback to states in terms of risks and vulnerabilities, I think that's something that we ought to talk about. And I think we can draw on some other work that we've done to bring that point home.

Then lastly -- I'll just stop and let others jump in. I think it's good to reiterate previous recommendations if we think they're still valid because I think to some extent, people may discount a recommendation that feels stale. So to the extent that this Commission can renew its call for more work in this area, as we have

described, I think that we ought to do that. And I think that would get some more attention, but I think we ought to be thinking about why we don't seem to be making progress and whether there's something that we can talk about that would help us making progress.

I believe -- and you touch on this question of the federal versus state relationship, where should CMS be spending its time and effort, the state sort of saying, "Well, this might be helpful," "That isn't so helpful." I believe that CMS should really be taking a kind of CMMI approach around program integrity, which is to say there aren't a lot of existing data collection, assessment, scrutiny over what works and what doesn't work, why something works or doesn't work, how it could apply to different state programs, and how it works in terms of affecting beneficiaries, providers, as well as costs.

I really do think CMS could be playing a strong role in the development of models and the funding of evaluations that would help actually increase the communities' understanding of what works and doesn't work and what's worth it and what's not worth it and what has potential negative impacts on providers and beneficiaries

and how those could be addressed by really initiating some activities that are designed to test, experiment, provide feedback, give insight into the kinds of measurements that might be meaningful.

So I think I would like to see us think about that a little bit more and what we could construct as a recommendation along those lines because I think that there has to be more -- I don't think that we can just go around and pick up available information. I think what you found shows us that available information is not just laying around, and so I think we have to think about how do we construct that information.

This is a very important part of both federal and state responsibilities is to ensure the program is operating as designed and is not vulnerable to fraud, waste, and abuse. And I think it's worthy of specific attention and specific efforts to model, test, and evaluate what works and what doesn't.

Kisha.

COMMISSIONER DAVIS: Thank you for this very detailed report, and I really appreciated the breakdown and explanation on the different areas.

I think, from a provider standpoint, it's -- and again, I'm thinking about, you know, beneficiaries and patients as well, it's pretty frustrating to be on the receiving end of these regulations and not be able to know or quantify how effective they are. As the one who's filling out the prior authorizations, that has to go through the background check, that has to, you know, work with patients on lock-in periods, that has to, you know, see these at that level, to then not be able to say, "Is this effective?" "How much is it saving?" "What's the benefit?" and you want to know that the program is being effective and efficient and that that can't really be quantified is really frustrating.

I think it would be helpful to even have a better idea of how much are states spending on these activities. Even if you can't connect it back to an ROI, can you say what percent of the budget is spent on program integrity efforts. I think that, even, is just helpful to know, you know, where this is going in the broader picture.

I think pushing back a little bit on the idea that, you know, prior authorizations, you know, make sure that only medically necessary things are provided to the

patient, in some cases. In some cases it results in a delay in care as you fight back and forth. And I often wonder, you know, all of the steps in time that are required for that process, for the patient who ultimately then does get that service, and all of the provider time and medical assistant and nursing time for the practice, as well as the MCO or Medicare that's, you know, doing that back-and-forth, how much money was spent to ultimately approve that drug or study or test? Did you really save money in that process?

And so I definitely would support us, you know, revisiting some of those recommendations from before. You know, I certainly would support making some comments on RACs, definitely exploring this more in a chapter, and thinking specifically about how do these regulations then trickle down to the beneficiary and the provider.

CHAIR THOMPSON: Okay. Bill and then Chuck.

COMMISSIONER SCANLON: Like Penny, I've had some exposure to this in the past, and it's been a while, and I actually feel fortunate that I think the world was simpler then. This was an incredible effort on your part. It was eye-opening to think about all the different aspects of

program integrity, activities that one can image. To talk about program integrity in Medicaid, is, in some respects, naïve to think of it as a subject. It's like it's an entire sort of litany of different things that you can do. And it becomes -- I mean, it almost becomes paralyzing to think about, well, what's the next step, I mean, when you think about these different things, and I think that some of our discussion needs to be focusing on that.

And it's going to be, I believe, in non-quantitative terms. It's going to be based on a lot of judgments about sort of -- and you talked about GAO and a risk framework -- judgments about sort of where higher risks are and where the greater potential is, even when we don't have numbers to sort of back that up. Because we've got to, my sense is, dig very deep into some of these things that have the greater potential, and that would be consistent.

Maybe CMMI would sort of introduce a demonstration to sort of test something out, but I think before we get there we need to really do a sort of mental analysis to decide sort of where, sort of, real potential may lie.

One of the things that was going through my mind sort of as I was reading this was, since we have become very much dependent upon the managed care plans, to understand what they're doing with respect to some of these things. I mean, prior authorization -- what do plans, how do they vary, et cetera? I've always argued that one of the real strengths of the private sector is it does things differently and can move quicker than the public sector can when it discovers that there's a better option, either because we learned our option wasn't good enough so we're going to try something different or they saw somebody else do something that they can move quicker.

So what sort of managed care plans are doing in this area I think is an incredibly important thing to understand. And it's not good to set regulations saying everybody has to do this. It's make sure that the message gets out about what can be sort of more effective, because they have a stake in this too.

The issue of data came up here, and it comes up repeatedly. It should be a principle, on our part, that we do not accept the fact that when we need data we don't get it, that when you need that information to make judgments

it has to be sort of a given that we are going to sort of have the ability to demand it and to enforce that sort of demand, at some point. So I think that, to me, is almost a recommendation that we may sort of have in the future when we identify data gaps, that we go there.

I thought you got most specific about the RACs, I mean, because there are certain problems that emerge there, kind of more readily. And there's a question there which is, are we applying the wrong model of RAC to Medicaid, where the situation is very different than Medicare, in terms of the potential. But yet some of the techniques that the RACs themselves use are things that we would really like to take advantage, and under what circumstances can we either use those techniques or get RACs to use those techniques for us. Because it kind of came down to that they're not being -- they're not receiving enough incentive to participate. I mean, that seems to be the fundamental thing. And is it our fault for that or is it that they have unrealistic expectations?

So again, an incredible experience reading this and feeling grateful that I never had to deal with the whole gamut at one time before.

CHAIR THOMPSON: Bill, just to clarify one point that you made. When you talk about looking at what the managed care plans are, are you talking about Medicaid managed care or are you talking about the commercial world and what they're doing?

COMMISSIONER SCANLON: It can be both.

CHAIR THOMPSON: Okay.

COMMISSIONER SCANLON: I mean, you know, my sense is that you don't miss an opportunity to learn. And I know that we -- and we do have sort of the Medicaid managed care plans within this program, and there is a reason to be looking at them because we're dealing with a different population than the private managed care plans, and potentially dealing with different sets of providers. And so the question would be, you know, is there anything that's particular to those circumstances that they've done that makes it more effective in terms of their improving program integrity activities.

But again, I'm totally open to learning from anybody.

CHAIR THOMPSON: Chuck, Sheldon, Darin.

COMMISSIONER MILLIGAN: Thank you, Jessica. I

think -- first, I think just a really good, strong, descriptive kind of piece is going to be valuable, and I think it adds a lot. I just wanted to give kind of three examples of pain points from different perspectives, some of which I don't think were developed real deeply. I wanted to talk -- and I think of them as program integrity. I'm not sure if they're in the rubric of program integrity.

I want to talk about one involving TPL and torts. I've been in a couple of different states where somebody on Medicaid is injured, they file a lawsuit -- car accident or medical malpractice or whatever -- the Medicaid program is paying for the cause of the industry, the person either settles or wins a trial in their case, but the judge refuses to kind of award back to the Medicaid agency the full amount out of that settlement or recovery the amount that the Medicaid agency paid for the care caused by the tortfeasor. And the judge's rationale, typically, is that would discourage the plaintiff from having an incentive to go to court, it's not equitable that they win and the state gets all the money.

And so it raises this issue -- and sometimes courts just ignore the federal law about how that's

supposed to play out. And so I think -- and then the states get in trouble with the feds for not adequately recovering. So I think there is a dimension about how some of the TPL plays out in the judicial system, based on, you know, medical malpractice or personal injury cases, and Medicaid paying for the medical care related to that. And it gets really thorny and it's a real pain point, because the agency has to assert its rights in court but they're not a part. The whole thing is a mess, which I've been on both as a general counsel for a Medicaid agency and also as a Medicaid director.

And I just wanted to kind of put that in front of you as something to consider in some form.

The second is COB, and the COB point I want to make -- and this goes directly to when I was doing the Maryland Medicaid work around individuals that have coverage, Medicaid is supposed to be secondary, but more and more employers are going to high-deductible plans. And so I will use the example of a woman giving birth and the high deductible is several thousand dollars, and it's hard to come up with the funds if somebody is also on Medicaid, they're poor enough to be on Medicaid, but they've got

health insurance that includes maternity care. And how do you -- MCOs would say "I'm not going to pay for that $5,000 deductible for that hospital-related delivery because I'm secondary" and yet the woman doesn't have the $5,000 for the deductible.

And so more and more, as employers go into high-deductible plans, I think it complicates the COB and it complicates the secondary nature of Medicaid as a payer, because these are individuals who are low enough income to be on Medicaid and yet they have private insurance, and yet that private insurance, increasingly, is going to high deductible, and how does that bipay work in terms of Medicaid program integrity and COB? And it's getting more pronounced. So I just want to flag that one for you.

The third one I want to flag is just -- and, Penny, you teed it up -- the cost avoidance versus kind of the pay-and-chase world. The federal OIG really likes the pay-and-chase because they like quantifying it and showing that you're doing it. It's harder to quantify the cost avoidance piece of it and it plays into rate-setting, and I'm curious about Stacey's view of all this, because rate-setting, the actuaries that do Medicaid rate-setting have

to take into account what is a fair expected value of the MCOs to do program integrity in terms of making an efficiency adjustment in the capitation rates the MCOs get, and it's cleaner if it's kind of -- we're going to deduct it based on actual recovered pay-and-chase dollars. It's harder if it's cost avoidance, and different MCOs are better or worse at those strategies.

And so I've seen examples, in Maryland, with rate-setting where the plans that thought they did a great job with cost avoidance didn't want to have a big cut to their rates out of presumption that they should be recovering more, and the plans that were recovering a lot arguably weren't doing a good job on the front end. So the pay-and-chase and cost avoidance and the implications with -- I mean, Bill, to your point, managed care organizations ought to be doing a better job, and, you know, authorizations and kind of having the right edits in place to not pay if somebody else is paying primary. But how that plays into the rate-setting process and program integrity is also a thorny issue.

And I think to whatever extent we can add some of the -- a little bit of that kind of disruptive flavor I

think would help, because those three examples I mentioned were the pain points I lived with more than some of the other kinds of pain points in this area.

CHAIR THOMPSON: Yeah. I don't know, Stacey, if you want to jump in and comment on Chuck's last part, particularly. You know, we did touch on that a little bit when we were doing some of the work on managed care and program integrity, but I think that, you know, that conversation has continued and that understanding and insight into the issues continues to get deeper for us. And so we should probably make sure that we reference and bring back in at least an understanding of those kinds of issues, because they are things that we have not grappled with successfully.

VICE CHAIR LAMPKIN: Yeah. And so I will just jump in and say it's very thorny territory when you're talking about the PI and managed care and how that intersects with rate-setting, where the incentives lie, especially, and how that works with rate-setting, which is not ideal.

And so I have been sitting here wondering, you know, I think this is a helpful foundational chapter for

talking about some different techniques, and I'm assuming that some of the pain points that you raised, Chuck, and some other points that we're talking about here are not to try to get into this potential chapter at this time but are more looking down the road and where we're trying to take the topic generally. I think there's a lot more to do in managed care, where a lot of these are, and I would throw estate recovery into that mix as well, as a particularly challenging situation as we have more and more managed long-term care programs with capitation rates.

So rather than going into the specifics, what I'd just like to agree is that this is a thorny issue and we've got a lot more talking to do --

CHAIR THOMPSON: Yeah, I mean, maybe there's more --

VICE CHAIR LAMPKIN: -- about managed care, specifically.

CHAIR THOMPSON: -- Jessica, that you could do just to reflect how some of the changes over the last few years have altered some of the dynamics. So --

VICE CHAIR LAMPKIN: That makes sense.

CHAIR THOMPSON: -- you know, your point about

high-deductible plans, your point about managed long-term services and supports, and so even in this environment where we're recognizing some of these have been long-standing parts of the program, some are newer, but things continue to change, and those changes continue to raise questions about friction with, or intersection with program integrity activities.

COMMISSIONER MILLIGAN: And I agree. I was not suggesting trying to do any analysis other than maybe teeing up, in a foundational chapter, that this is an area of future work.

CHAIR THOMPSON: Yeah. Okay, Sheldon and then Darin.

COMMISSIONER RETCHIN: Thanks. I too have a little experience with program integrity as hunted prey.

[Laughter.]

COMMISSIONER RETCHIN: So I actually, seriously, want to emphasize what Kisha said, because there's another side of this. Especially, I guess I would probably underscore the experience with RAC vendors. It's always disconcerting when a RAC vendor buys a condo next to your medical center.

But I guess, you know, when I look at the figure that's there that shows this declining -- precipitous decline in recovery from RAC audits, and then reflect on the Medicare program, I'm wondering what's amiss. Is it the conversion to managed care? But, in general, Medicare has also suffered from the experience of having RAC vendors go around, get bounty for the recovery.

There is a, I think, a pervasive downside for providers, and I think this does feed into what we'll talk about on the participation rates for providers. You're asking providers to take a haircut on the actual payments and then come around and be audited by private vendors. There is a downside. And Peter Cunningham has written about this, in terms of the administrative costs for -- in terms of the negative participation rates by Medicaid providers.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: In a sense, you know, I am going where Chuck went. Managed care, there's a lot of things that -- and points that Stacey made -- that are worth discussing, because it does introduce a lot of different factors.

You know, many states who aren't required through managed care to do RAC, we did, but, you know, if you don't understand how those states are set up, like ours were, if the plans identified and captured in the year then that's theirs, what was left, you know, if RAC found anything after that period it would be theirs. And so you could look and say, well, RAC wasn't effective, or was it, because it incentivized plans to be more timely in what they're doing.

Or the fact that, you know, you get into situations where we would have -- and this isn't a good thing; this is just how complicated it gets -- where plans would remove providers, would not classify that as fraud or abuse, they'd remove them without cause, because it was the least path of resistance, which created challenges because we had other plans contract with those providers, and so we had to be a little bit more diligent in working with the plans to really understand those things.

So it gets -- there's a lot of places we could and should go within managed care and understanding and appreciating where there's some challenges and where there some potential improvements in the overall system.

The other thing I will say, and this is really not relevant, or not tied specifically to managed care, but I think when we get to ROI it does get very complicated, obviously, as you've identified. But one example where we had made some false assumptions on our side, and, you know, as I've spoken more with providers I learned that we had misattributed things as fraud and abuse, which were really tied to something totally different. Which, for example, EVV. When you look, initially, when it was rolled out, there was substantial change in what we were seeing was going on, and we did it. You know, it was fraud and abuse but it was also a quality-of-care concern, identification gaps, et cetera. And when we saw the drop we were saying, like there were all these issues, you know, that we're identifying, because of EVV, some fraud and abuse, some missed visits.

And what I later discover is was because multiple plans have different processes and you had low-wage workers trying to navigate three complicated systems by which to, you know, do their job. And so it was a lack of ease that contributed to some of what we saw, not that they did anything wrong. And so that's interwoven within that, and

it makes it really hard to kind make sure. You make some false assumptions just saying there was a cause and there was an effect, and you bucket that sometimes inappropriately.

CHAIR THOMPSON: Okay. Let's pause here and then see if we have any public comments.

[Pause.]

CHAIR THOMPSON: Okay. So I think what I hear is the Commission wanting to see this convert to a chapter in June. I think there's a variety of things that we've suggested about bringing in some different topics or adding some additional detail here.

I think in terms of next steps, we want to talk about the fact that we need to have a broader understanding of performance that understands impacts on beneficiaries and providers, that ensures that we're not crediting or overcrediting recoveries rather than prevention. I would like to see us think about whether there's something we can construct around a more deliberate and conscious and intentional activity to test and experiment and collect data and provide feedback that gives us some of those broader understandings. We have a potential to look at

other payers or at plans to see what they're doing, and certainly a lot of interest in managed care in general, in terms of continuing the work that's represented here but also that we did earlier in looking at some of the issues around managed care.

And I want to pick up on Chuck's points too, about some of the COB and TPL issues. I think those may need their own attention. I'm not sure -- and I think because I do have a client that's involved in the RAC work, that I'll recuse myself from any conversation around where we go with recommendations on the RACs, so I'll let Stacey pick up that point. But I think we do want to resurrect and revisit some of our earlier recommendations and see if we can expand or augment those to see if we can think of some practical additional suggestions that need to be taken, that can help fill in some of those gaps or that can be the focus of some activity by CMS in helping to make progress on that.

COMMISSIONER BURWELL: Is our intention to post the Myers and Staffer report as a standalone report and do a chapter, or is that only going to be used as background for the June chapter?

EXECUTIVE DIRECTOR SCHWARTZ: I think our plan is to use it as background for the chapter.

COMMISSIONER BURWELL: Okay.

EXECUTIVE DIRECTOR SCHWARTZ: It's written by auditors so it has a lot of information in it --

CHAIR THOMPSON: God bless auditors.

EXECUTIVE DIRECTOR SCHWARTZ: -- that's hard to read.

COMMISSIONER BURWELL: I don't think I'd read that.

CHAIR THOMPSON: Martha.

COMMISSIONER CARTER: I think I'd like to see, to Kisha's point and Sheldon's point, to the extent possible, some discussion of the bigger cost to the system of these PI efforts. I know that's impossible to quantify.

CHAIR THOMPSON: That's what I mean by talking about performance more broadly --

COMMISSIONER CARTER: Okay.

CHAIR THOMPSON: -- than just, you know, a return on investment, but understanding beneficiary and provider impacts, including the costs of compliance, including what that means for participation. You know, for beneficiaries

-- we've been talking a lot about providers here, but for beneficiaries, for example, you know, the more documentation there asked for, in terms of an eligibility process, the more potential there is to lose them in that process. So those kinds of things, I think, are worthy of attention, and ensuring that whatever we're suggesting about looking at whether an investment is worth it needs to take into view some of those kinds of impacts, even if --

COMMISSIONER CARTER: I guess I'm calling them costs, and I think that's an important point. They're costs. They're just not quantifiable sometimes, but they're still costs.

CHAIR THOMPSON: Okay. Sorry. Alan is trying to get in, and then Bill.

COMMISSIONER WEIL: I had two reactions to this. The first one is easy to say and hard to do, but particularly with the addition of some of the commenters about adding yet additional techniques. I think this calls out for a bit of a typology, for lack of a better word. I for one, when I read the report, I never thought of prior authorization as a program integrity activity. I mean, maybe I'm the only one, but it's sort of -- you know, to

me, there are really differences in kind about what we're trying to accomplish, and so I think it's hard to have a list of a lot of things and just sort of say here's what they are without some organizing theme. And as I say, it's real easy for me to say that. Now you get the task of seeing if there's anything possible to do with it.

EXECUTIVE DIRECTOR SCHWARTZ: We'll make you draw the picture again.

[Laughter.]

COMMISSIONER WEIL: Yeah, exactly. Exactly. And that I think ties a little bit to the second comment, which is a variant on some of the early notes about the effects for other people. But because I think the costs and benefits are multidimensional, I actually think the more interesting question here is cross-state benchmarks on particular techniques rather than aggregate it's better to put your money into this recovery than that audit. If I'm trying to run a program and thinking where do I put my resources and I'm seeing -- you know, sorry, this is a longer comment than I expected. The issue with PARIS, I mean, I heard about that 20 years ago. So there are states that have decided that for certain populations PARIS is a

great way to do avoidance, and that idea has been promoted for decades. So to me it's more interesting to ask the question who's using it, who's getting the most from it, rather than should you be investing in RACs or changing what they do versus -- that felt to me -- that feels to me like given the multidimensional costs and benefits, having comparisons about how a single technique performs across locations seems to me to be more likely to be of value than trying to compare a single dimensional ROI on fundamentally different techniques.

CHAIR THOMPSON: I just want to be sure, Alan, I understand one point, which is so for all of these we have multiple states who are using these techniques, and -- I mean, you would presume that at some level these could be useful, right? It depends on where your focus is. It depends on how you do it. It depends on the relative amount of energy you have to expend and whether it's -- you know. But all of these have multiple states who are doing them, so are you saying the frame of analysis is horizontal, you know, rather than vertical, effectively?

COMMISSIONER WEIL: Like every question we grapple with, at some ideal point I think it would be very

interesting to look at this vertically so that the country and individual states but the federal government through federal policy could make wise decisions about the relative ROI, if you will, for certain things. And part of why I started with the typology is -- and forgive me for not having a ready example in my head, but if you take two things that are fairly similar and say this one works better than that, that's useful. But, again, you know, prior authorization has lots of care quality implications that are never going to get captured in an ROI calculation. So even if you could get all the states to think about cost avoidance the exact same way every time they do prior auth and line up that cost avoidance against cost avoidance for third-party liability, I think it would be very difficult to have a vertical decision rule that says it's better to invest in third-party liability than prior authorization because the metrics are different.

Could we get to a place where you could put two or three of these next to each other and get consistent ways of thinking about what are the costs, who bears them, what are the benefits? I do. When the list is now going to be like 12 because we just added a few, that's when I

get skeptical.

CHAIR THOMPSON: Yeah, and I agree with that. I also think that, you know, even within something like prior authorization, it's like, well, prior authorization for what, right? And there can be a very big difference as to whether or not you're operating a prior authorization program for one kind of benefit versus another kind of benefit or one program -- so indeed that is in part what I'm saying about you actually have to construct some models in which you can get to a level of detail that is meaningful and extract the kind of information that will give you insight into how does that work and is that worth it.

So I think that wherever we go next, I don't know that we continue to carry the list of 10 or 12, right? And part of what I hear some people talking about is maybe we need to pick off some more granular targets that give us a little bit more of that texture.

Okay. Bill, and you will have the last word.

COMMISSIONER SCANLON: Okay, and I was just going to follow up on targeting of a different sort. The question of sort of the burden on providers, I think that

one of our principles has got to be that you target these activities on where you think the problem is, that you don't make it sort of a universal burden for everyone. And associated with that is the fact that the resources going into program integrity are so limit that if you spread them over the universe, you're not going to get a very good return.

Now, targeting is not an easy task, but it is something that you do need to be thinking about how you can find means to target because otherwise the return is not going to be anywhere near what you would hope for. And we really do have limited dollars that we spend sort of on program integrity activities. Any study we did, we would just find that it was just a really minuscule fraction of activities that were ever sort of looked at in any kind of detail.

Now, interesting that prior authorization has come up here today because I think that's a reflection of we now are more into a digital world and we can actually do more things where there's maybe at the back end, where the reviewer is, there's less -- there are fewer resources that are required and so you can make a requirement more

universal, and that's not necessarily the best thing to be doing.

CHAIR THOMPSON: So that'll be -- I'm sorry.

EXECUTIVE DIRECTOR SCHWARTZ: Can I ask a question to help us figure out the framing for our next product? Part of what I'm hearing is some kind of piece that requires some reimagining -- bringing in our old work -- but reimagining what the PI framework, what we're all about here, what Medicaid activities should be a part of. Then somehow we would move that forward along with some very specific information from this contract. Some of that can fall out, and we can figure out other ways to deal with it.

But I think I also want to just test an idea, which is part of the reason we have all these multiple things that keep piling up is that every time Congress needs an offset, they do something on PI. It's perceived as getting rid of the bad stuff. We don't touch any of the good stuff and there's savings. Plus it's not so much focused on, well, this policy should change certain behaviors, so the bad stuff doesn't happen. It's more about the savings that we could garner from that new

policy.

CHAIR THOMPSON: Well, and that gets to scorability --

EXECUTIVE DIRECTOR SCHWARTZ: Right.

CHAIR THOMPSON: -- which is another aspect of calculating and what you count and what's easy to count and privileging the things that are easy to count rather than the things that are potentially more meaningful.

EXECUTIVE DIRECTOR SCHWARTZ: And so is that okay?

CHAIR THOMPSON: But that's part of the conversation about broadening the scope of understanding what performance is really about and how do we help move that ball.

EXECUTIVE DIRECTOR SCHWARTZ: And so if we conceptualize this as a chapter that talked about the broader activity, what we're trying to accomplish, bring in some of the gaps in our knowledge that we previously pointed out, bring in some of the concerns related to managed care that we previously noted, and use some of the work that we did in this project as examples of that, does that feel like that --

CHAIR THOMPSON: Yeah, I think that's --

EXECUTIVE DIRECTOR SCHWARTZ: In which case it --

CHAIR THOMPSON: And I think in that middle part, it's a little bit about also recognizing as delivery systems change, as insurance models change, what does that mean in terms of -- so that we're not -- we're also not just in this old world where we're just pulling up the same old approaches and tools and thinking about that -- you know, a great example of that is, you know, we talk about provider enrollment here and provider credentialing, but we're also in a movement where we may be involving more workforce that doesn't go through a particular qualification exercise, and so how do we apply some of those kinds of things?

So I think there are some places here where we can talk about those environmental changes and how well our old techniques or tools may or may not fit with that.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. I'm just trying to think about what's our next thing that we can bring to you, and it sounds like it's not so much a decision memo. I'm not sure if we're ready to vote on recommendations, because we don't have any rules on this

about whether you need to vote on reiterating an old recommendation. It doesn't seem to me like you should have to, in which case, we might be better off coming back in March with something that's a little bit more thematic, here are the high-level themes that we might want to focus on, rather than waiting, you know, to write the full chapter, so like have we gotten the Gestalt of this right?

CHAIR THOMPSON: Yeah.

EXECUTIVE DIRECTOR SCHWARTZ: You know, the key themes and the subpoints of that, and then have you zero on whether that's the right neighborhood before we go ahead and start writing the thing. So --

CHAIR THOMPSON: That seems fine. I will say I think I would like to see us move to an update of a recommendation.

EXECUTIVE DIRECTOR SCHWARTZ: Okay.

CHAIR THOMPSON: I don't think it's necessarily a reiteration, but I do think again it draws attention to an older recommendation. If we have some new evidence that shows that it continues to be something that needs to be acted upon --

EXECUTIVE DIRECTOR SCHWARTZ: Okay, so you think

there's value in the --

CHAIR THOMPSON: I think there's value in that. I think there could be value in, you know, some revisions and additions to that --

EXECUTIVE DIRECTOR SCHWARTZ: Okay. That's helpful.

CHAIR THOMPSON: -- that are worthy of thinking about.

EXECUTIVE DIRECTOR SCHWARTZ: Okay, thanks. That's helpful.

CHAIR THOMPSON: Okay. Any final words from Commissioners before we break for lunch? Jessica, any reactions? Questions?

MS. MORRIS: I just wanted to make sure that we've closed the loop on the discussion of the RAC which you had said might be something that Stacey would chair and so if --

CHAIR THOMPSON: Yeah. Let me just turn to Stacey for that.

COMMISSIONER LAMPKIN: Yeah, so I am trying to think how that fits into this. My sense about the RACs, reading the chapter myself and listening to the

conversation today, is that -- I mean, it certainly seems without some change to the structure to be not necessarily an efficient requirement and process. Whether that means that we're in the mood to recommend that it become optional instead of mandatory -- I didn't hear a lot of people speak to that. You know, Darin spoke to the fact that in Tennessee they made it more relevant by bringing in the managed care program, so I don't know if we have additional information of how many states have approached it that way that would help inform our discussion. So I would just say maybe this could be something that we talk more about next time, and if you have additional insight into the states that are continuing to use it, why and how it's relevant, how they've made it relevant, that could inform that discussion.

MS. MORRIS: We have some information. I'd have to look closely at it again and see if there's anything of value to bring back. But I couldn't say exactly how well it's quantified at this point.

CHAIR THOMPSON: Okay, good. Jessica, thank you. That was worth waiting for. And we will reconvene at 1 o'clock.

* [Whereupon, at 12:19 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. Let's do a 30-second warning here as people wrap up conversations.

[Pause.]

CHAIR THOMPSON: Kirstin, you're going to kick us off for our afternoon session and talking about the Financial Alignment Initiative and factors affecting beneficiary enrollment.

FACTORS AFFECTING BENEFICIARY ENROLLMENT IN THE FINANCIAL ALIGNMENT INITIATIVE

* MS. BLOM: Thanks, Penny. Good afternoon, Commissioners.

Today, I'm going to walk through the results of an analysis that we just completed. We contracted out to identify the primary and secondary factors affecting beneficiary decisions to enroll in and stay enrolled in the Financial Alignment Initiative. The contractor report with detailed results and data on enrollment in each state will be available on our website later today.

Just to give a quick overview of the Financial Alignment Initiative, beneficiaries began enrolling in

2013. It's a CMS demonstration designed to test models to align Medicare and Medicaid financing and integrate care for dually eligible beneficiaries.

Most states are testing a capitated model, and one of those states, New York, is operating two demonstrations.

Under these capitated models, states and CMS sign a three-way contract with health plans, referred to as Medicare and Medicaid Plans, to coordinate benefits, and our analysis focuses on the capitated model.

Over the years, Commissioners, like many policymakers, have expressed interest in lower than expected enrollment in the demos, and to respond to that interest, we contracted with Mathematica Policy Research to analyze the factors affecting beneficiary enrollment decisions.

This analysis expands on prior research by looking at all participating states rather than just a subset of the states with capitated models over the life of each of those states' demonstrations.

Mathematica used a mixed-method approach to identify factors associated with higher or lower enrollment

and the degree of influence of those factors on enrollment.

This approach combined the results of several quantitative analyses as well as qualitative interview results. The quantitative analyses included a temporal analysis to determine whether a major change in state policy or strategy was followed by a marked change in enrollment, assessing whether certain state enrollment policies or MMP characteristics were more common in states with higher or lower participation rates, and examining state and MMP respondents' ratings indicating the degree to which they thought certain program elements either promoted or hindered enrollment.

Data sources that we consulted included CMS's Annual Medicaid Managed Care Enrollment report, Financial Alignment Initiative web page; for states, three-way contracts, state data, and of course, interviews with state officials and MMP representatives.

We interviewed state officials in each participating state with a capitated model and also representatives from 15 Medicare-Medicaid Plans with higher enrollment relative to other MMPs. We talked to them specifically because of their success in enrolling.

Our analysis set out to answer these three research questions, looking at which states and MMPs have been most effective in enrolling duals, eligible duals to date, and increasing participating rates over time; trying to find out which state policies and strategies have been most and least effective in increasing participation rates among eligible enrollees; and looking at whether or not certain MMP strategies or characteristics were associated with higher enrollment levels and enrollment growth.

Beneficiary participation rates have been lower than expected in all states, as you know. Overall, about 29 percent of eligible individuals are enrolled in the capitated models. Rates, of course, vary by states, from a low of 4 percent in New York to about 67 percent in Ohio.

These rates reflect the enrollment of full-benefit dually eligible beneficiaries, those individuals who are eligible for full Medicaid benefits. Partial-benefit duals are excluded from the demos.

Enrollment is voluntary, and beneficiaries can enroll, disenroll, or change plans at any time, which is consistent with longstanding Medicare policies around enrollment for duals.

I do want to note here that in the recent Medicare Advantage rule, there were changes made to the number of times a person can change their enrollment. It's now limited to three times per year, but FAI states were given the option to waive that for the 2019 contract year, and they all did. They'll have another opportunity to consider that again in 2020.

This figure shows beneficiary participation rates by state, but I think it's probably a little bit small for people sitting behind me to read. So I'd just like to point out that the beneficiary participation rates, the bars are for each state. The states are across the bottom, and each bar represents a particular year of the demonstration, starting with 2014 through 2018.

Obviously, you can see a wide range of participation rates across these states, and you can also see that participation rate varies within a state, depending on the year.

Factors affecting enrollments are grouped into primary factors and secondary factors, like I mentioned at the outset. Primary factors that we identified are considered primary because they were identified by 15 or

more of our interviewees. Secondary factors were identified by less than 15, but more than five.

Of the primary, three were associated with higher participation rates, passive enrollment; alignment of key structural features of MLTSS with the duals demos, such as the same eligible populations, same geographic areas covered, and same participating health plans. And then the third factor is relationships of care coordinators including contact prior to passive enrollment and face-to-face meetings with new members as soon as possible after enrollment. None of these are particularly surprising, but it's helpful to have them documented.

One primary factor was associated with lower participation rates, which is insufficient LTSS provider support and engagement with MMPs. This is LTSS providers, including nursing facilities and home and community-based service providers, whose patients were eligible to participate in the demos, but where in cases some providers refused to join the MMP network or actively discouraged their patients from enrolling.

In this table, you can see all of the primary and secondary factors that we identified and whether they were

associated with higher or lower enrollment. I've talked about the primary factors, but there are several secondary factors I'd also like to point out.

Medicaid deeming policies were noted by our interviewees, were associated with higher enrollment. As you know, in states with Medicaid deeming policies an MMP may consider beneficiaries as enrolled, even if they lose Medicaid eligibility. Beneficiaries often lose eligibility at redetermination because they haven't provided the documentation in a timely manner, but then regain it very quickly. So this policy is meant to provide a grace period of usually two to three months for people to regain Medicaid eligibility.

A secondary factor associated with lower enrollment was the ability to change plans at any time. Changing plans at any time, as I said, is a longstanding Medicare policy, but several interviewees noted that this increased opt-out rates and decreased enrollment retention.

MMPs said that beneficiaries opted out in some cases before even experiencing coverage under the demonstration, sometimes on the advice of their providers.

There's been a lot of interest in enrollment

brokers, and so I wanted to just note here the states and MMPs we interviewed were divided as to the effect of enrollment brokers on beneficiary participation. States saw them as increasing enrollment, but MMPs saw them as decreasing it. States felt that brokers augmented state capacity to handle calls, to conduct outreach, and also served as a neutral entity that beneficiaries could trust to help them choose an MMP.

MMPs felt that brokers were not knowledgeable enough to properly assist beneficiaries in choosing the best option, did not have enough time to work with beneficiaries, and ended up creating confusing and adding complexity to the process.

The presence of competing managed care products in an FAI state and the financial incentives associated with those products also affect enrollment. Beneficiaries in many states have numerous coverage options in addition to the MMPs, including programs like PACE and a variety of Medicare Advantage special needs plans like D-SNPS and FIDE SNPs.

Plans and others assisting beneficiaries with enrollment choices may have financial incentives to steer

beneficiaries away from a particular product. For example, in New York, there was an incentive to keep beneficiaries in FIDE SNPs because FIDE SNPs are eligible for a frailty adjustment that's not available in an MMP.

So that concludes my review of our key findings, but the analysis raises several policy questions for further consideration, which we've listed here. Commissioners may want to use today's session to talk about any of these that are of interest or on the next slide, and these questions could suggest areas for future work for us. So we'd be really interested in your thoughts on these and on the direction forward.

And I'll stop there.

CHAIR THOMPSON: Great. Thank you.

Melanie is going to kick us off, followed by Brian.

COMMISSIONER BELLA: That's a surprise, right? I was actually going to try to not go first today on duals.

CHAIR THOMPSON: I'm not letting you off the hook.

COMMISSIONER BELLA: Thank you for this work. I love it when we're investing in this space.

A few comments, and maybe I'll start with -- so let me step back and then hit some of these. I think that there's a couple of areas that would be really helpful for us to understand, and one is I don't -- I think it's clear that eligible beneficiaries and their providers don't have a good understanding of the value of integrated care programs, and it's really difficult to explain that.

And so there was work actually done. The SCAN Foundation funded beneficiary surveys, and at one point, 43 percent of beneficiaries said they didn't even know they had opted out. So these were folks that had been interested in being in the program. They didn't even know they were out. So you have people that don't know they're in, but it was really surprising then to have people that don't know they're out who want to be in there.

Similarly, post-CMS, I had an opportunity to meet with real providers. I don't know why, Penny, we don't get to do that more at CMS.

This was in California where beneficiaries had an option of PACE or a D-SNP or a demo plan or a regular MA plan or a fee-for-service. These providers are looking at me saying, "I don't even know what this is. So, yeah, I'm

not telling people to be in these programs because nobody has even explained to me what it is. So if they knew that this program could get that person, their patient, transportation and meals and care coordination, maybe they would have thought differently about how to advise, and they're a trusted advisor.

So I think that I would encourage us when we think about what we might consider, we've got to get to actual people and actual providers and figure out better ways to convince them, whether it's the MMP or whether it's a FIDE SNP or something it's anything, kind of the value of these programs. So that's one comment.

The second comment is I don't think we can underestimate the power of conflicting incentives. It's no surprise that New York's enrollment rate is 4 percent. New York's plans had every incentive to put beneficiaries in other products, and that played out. So until we recognize that when there's conflicting incentives either for the plans or for the Medicare enrollment workers or for providers, then we shouldn't be surprised that we see -- they're acting just the way the market is set up. So I think if we're going to dig into this, we've got to

understand do we want to take a position where there's multiple things that oftentimes add confusion to beneficiaries and providers or do we want to try to focus on a certain core set of things for integrated programs.

I'll get off my soapbox in a minute.

Specifically for these, I'd just mention a couple of comments. So there's a question about default enrollment, and I'm not sure how many folks are familiar with default enrollment. Essentially, if somebody ages in to become a dual and they have a relationship with their Medicaid plan and that Medicaid plan is in Medicare, they can pull them over to serve them on the Medicare side too.

In the demos, most of the states have the ability to have ongoing passive enrollment for newly eligible, which is basically the same thing as default. So I'm not sure that there's much -- the point was the demo states can't do this. They have a different mechanism for doing this. I'm not sure there's a lot of bang for the buck there.

If we're going to look at notices, it's important to look at the MMP notices, but part of the reason the MMP notices are such a mess is because all of the Medicare

notices are still in use. And Medicare has 20 or 30 notices, and so to try to combine that with an integrated notice is really confusing. So we have to kind of look at that base.

Lastly, there has always been this assumption that because people can switch plans anytime that that's what's leading. That does lead to churn, and then CMS did make a change. As you noted, all the demo states opted out of that change, and I just want to make sure people understand why.

The benefit of changing the special enrollment period is it reduces churn. The downside of that is if somebody wants to get into an integrated product, they can't for each quarter. Also, when you're coming in and you're a low-income subsidy enrolled beneficiary, you get put into a Part D plan often, and so you would be sort of locked into that plan for a quarter.

The reason the demo states don't want to do that is because if they have someone that wants to join their demo, they want them to be able to join tomorrow, and so one thing that we might think about as a Commission is perhaps it's appropriate to make the changes to the special

enrollment period, but perhaps you would allow people at any time if they want to opt-in to an integrated product. I think that kind of thing would enforce the direction that we would be going in terms of furthering integration.

So, with that, I really will stop, but thank you.

CHAIR THOMPSON: And some of that is also -- your reference to these areas where there is just such a lack of understanding. I mean, that just complicated all of this decision-making and sort of path-setting for people if they don't even know. If they're in or out or what the value of this is, then how can they make choices?

I've kind of given up on notices. They just don't work. There has to be other kinds of engagement strategies that really help people understand.

COMMISSIONER BELLA: Well, last comment on that point.

CHAIR THOMPSON: Yeah.

COMMISSIONER BELLA: Within the opt-out in various states, it's different among subpopulations in the duals, right? So kind of looking writ large at an opt-out rate, you've got to get under the hood and understand.

In California, 90 percent of the opt-out was for

people that had in-home services, many of whom were family members, and they were worried that they were going to lose that. That's what drove that opt-out rate. Until you get under the hood and understand, maybe in some places, it was people with serious mental illness. That should say to us we need to refine our notices and our education strategy differently for different populations if we see different patterns of opting in and opting out.

CHAIR THOMPSON: I think this also gets kind of to an issue we touched on before about just how do we engage beneficiaries and providers in a bilateral conversation in which we are giving them information, but they're also giving us feedback. And we're both using that to kind of refine our understanding about how to move forward.

Brian, why don't you jump in.

COMMISSIONER BURWELL: So I also am very glad that we're getting into this area, a very important area, and I look forward to reading the full MPR report.

I guess one of my major responses is just reading this part or a summary of the report. It's kind of the frustration of not having more of the detail and the

context around these enrollment data.

I don't know how much the full report gets into this, but each market and place where states were before the demonstration is very important. Was the demonstration built on an existing mandatory MLTSS program, or was it just a standalone voluntary program and all those kinds of things? Different states have different rules about if you disenroll. How much was this enrollment determined by initial enrollment, say in a voluntary state, or how much is it influenced by disenrolling and people were passively enrolled and then they opted out? So there's just a lot more complexity to these numbers.

MS. BLOM: Yeah. There's a lot more detail in the report. There's a whole set of appendices to look at. There's some graphs in there to look at, where states were before the demos began. There's a graph on the presence of D-SNPs in the states to try to think about the competing incentives questions. So there is more detail in there, a little more than could be put into this memo.

COMMISSIONER BURWELL: I look forward to reading that.

Then I guess my only other thing would be in

terms of further consideration of the demo has occurred. I don't know what the future of it is, but also maybe the next study or the next iteration, bringing in the non-demo states. I mean, just more and more states are trying to build, integrated care products off mandatory MLTSS and D-SNPs, and a number of states have been very successful in increasing dual enrollment across those two products, the Arizonas, Tennessees, et cetera. That would also be an interesting comparison of how those enrollment data are compared to what we've seen out of the demonstration.

MS. BLOM: We're definitely thinking about that.

There's also some states that have left the demos and are now doing their own --

COMMISSIONER BURWELL: Right.

MS. BLOM: -- sort of modification, modified model. So we're definitely interested and planning to look at those.

CHAIR THOMPSON: Darin and then Sheldon.

COMMISSIONER GORDON: Thank you for this. Very helpful.

On your questionnaire or consideration about how can states ensure that provider networks are adequate in

integrated care programs, I think one thing -- and this was brought to my attention when we're talking about the variety of factors, why you see in some states lower participation rates, and the default enrollment that both Tennessee and Arizona -- and you can go and compare these, but when we looked at it and CMS looked at it, it was in the low 90 percent range. So it was up higher, but there's probably a lot of factors to consider in that.

But one thing that we were talking about, what are some of the things driving that, someone brought it to my attention. Someone should look at -- I thought this would be something worth us looking at, actually. When you look at the networks, how much overlap or lack of overlap there is, and in particular, take a look at what states do with regards to their policies for Medicare crossover payments, and see if that has contributed to an imbalance of the overlap of the networks and/or participation. I was like, yeah, it's a very, very valid point because I think, historically, states have looked at that, that particular budget item very myopically, and not looking at it now as the world has moved toward greater integration approaches about how that interplays with participation and integrated

products.

CHAIR THOMPSON: I think, Sheldon, you were next.

COMMISSIONER RETCHIN: This is really great work, Kirstin, and I appreciate Mathematica's effort.

So a couple of points. One is, I was talking with Melanie before, there are a bunch of studies circling around this, from CMS, and now us, and I guess I would be pleased that we try to put it all together, because some of it is duplicative and overlapping. But so far I haven't seen any of the contractors or the efforts to actually -- I mean, this is radical -- but actually ask the beneficiaries, just to ask them why did they disenroll, how did they disenroll, and whether there are beneficiary characteristics here that might explain some of the variation. Because one of the earlier studies actually showed that -- you could imagine this might happen, but that sicker duals actually disenrolled at much higher rates, which wouldn't be shocking.

But the other thing, just an observation -- oh, and then one more was the majority who disenrolled or opted out, Kirstin, do we know where they went? The majority went to fee-for-service, I believe. Is that true?

MS. BLOM: Yeah, I think so.

COMMISSIONER RETCHIN: Okay, which is interesting, although I thought -- think there was a significant number who, while they had not had MA experience before went into Medicare Advantage plans, and I think that's happened in Ohio.

But then just an observation, is, which is extraordinary to me, if you look at some of these plans and the opt-out rates are like 70 percent, I almost want to learn from that, like how does a dual figure that out? It must be either important or they just kind of called the wrong number? Like that's just -- and you can't get populations to do anything at 70 percent, even though this is negative. That's why I still think we ought to -- we ought to contact beneficiaries there. There should be some surveys.

CHAIR THOMPSON: I think Alan might want to jump in and say something about that.

COMMISSIONER WEIL: Yeah. I mean we had a paper in September of 2018, looking at California beneficiaries. Now that actually, that analysis did not include an opt-out population because the numbers in California are relatively

high. We also had a 2017 paper by David Grabowski and colleagues at Harvard on passive enrollment.

So just to echo, there's a literature around this that we're contributing to, and this analysis adds to it. But I think it is important that we look at these in the context of multiple people trying to figure this out.

CHAIR THOMPSON: Kit and then Peter.

COMMISSIONER GORTON: I'm just struck by the enrollment broker observation. I mean, does it cause higher or does it cause lower? It wouldn't -- it would seem that -- I don't understand how those two different perceptions can be reconciled. So I guess, is one right? Is the other right? Are they both right but they're looking at different parts of the elephant? I would be intrigued about what's going on there, in part, following up on our earlier conversation. Those independent enrollment brokers are not free, and so if they're creating value in the program then somebody ought to demonstrate -- and we're not the primary value raters here -- but to me somebody ought to demonstrate that they're creating value in the program and justify having them there. And if they're not creating value in the program then we should

stop -- then they're a drag on time and resources and everything else and we should figure out what the next mousetrap is.

So I personally would be interested in figuring, you know, to Alan's point, if somebody's already studied it then can we shed some light on that? But that just jumped off the page at me, that difference in perspective.

COMMISSIONER BELLA: Since you said that states felt one way about the enrollment brokers and the plans felt another way, are we sure the plans weren't talking about the Medicare sales brokers, because that's what the plans are complaining about because brokers were outlawed in many states, as you know, and so the demo plans feel like they can't compete when the brokers are getting incentives to put people in a different Medicare program. So are we sure we're talking about the same broker?

MS. BLOM: I'm not sure, actually.

MS. LIPSON: I could answer that, actually.

MS. BLOM: Debra from Mathematica is here.

CHAIR THOMPSON: Come on up to the table. We're always looking -- yeah, okay.

MS. LIPSON: Is this on? Okay. I think so, yes.

All right. There's two different broker dynamics going on here. One was the independent brokers, those who are freestanding and get commissions from plans, and, you know, can steer beneficiaries all sorts of places, depending on what the financial incentive is to the independent broker. The issue that we identified as a secondary factor that influenced enrollment in these states was the state-contracted enrollment broker, the most common being MAXIMUS, right. MAXIMUS is the contractor, in, I don't know, like 90 percent of the states right now, for all managed care, Medicaid managed care, and many -- I think all the states -- I think -- I'm not sure whether all or most of the FAI demonstration states contract with the same enrollment broker to help answer beneficiary questions about their plan options, and so on and so forth.

That was the issue that we found the division between the states. States said, well, we couldn't handle all of those calls coming in from beneficiaries, we really need the support of those enrollment brokers, we really need them, whereas the plan said whenever beneficiaries ended up going in through that system they got the runaround, they got wrong information, you know, sometimes

it, you know, it added complexity to the whole process and they were getting mixed messages. So that was the issue.

The independent brokers, in some states, was very operative, and California comes to mind, where those independent brokers are going after a lot of different commissions.

CHAIR THOMPSON: Thank you. Toby, were you trying to jump in on this point?

COMMISSIONER DOUGLAS: Yeah, on this one, because I think there's just a little bit of an underlying on the second piece, or on the enrollment brokers, this tension on the plan side. So you go back to the D-SNP and MA, is there is an ability to enroll by the plan, whereas in the MMPs, or at least in California, the enrollment has to flow through the enrollment broker.

So it's this tension here of you have maybe the enrollment broker from a state who is doing a really good job and maybe the plans think that, but it's this extra step that is the tension, which I'm assuming that's what's really the underlying tension, from a plan standpoint.

And just one, while I have it, is I do want to say, one other piece, and it gets to just how difficult it

is to tease out these. You know, California, you can't just look at one opt-out rate. The rates vary significantly by county. And so there's just so many other, you know, factors. While these are true, there's just, you know, other things going on that make it county by county, or, you know, geographically so that you can't just look at California as a whole. And I would assume the same in other states.

CHAIR THOMPSON: Peter.

COMMISSIONER SZILAGYI: This is getting off the point of the enrollers.

In the figure that you showed where you looked at the beneficiary participation rates, I was struck by a couple of things in addition to the variation across states. Other than the first year, there was really tremendous stability. I mean, it didn't -- in many new programs participation rates go up with experience in the program, and that didn't happen at all here. And I was wondering about what are the disenrollment rates? Maybe I just totally missed this. Is this sort of, almost not churning, but is the enrollment and the disenrollment kind of equalizing across years here? Is that why, you know,

the states have stuck at whatever level they got to, so South Carolina at 30 percent? Is disenrollment very high, and is that a reflection of quality?

MS. BLOM: I think that's a good question. I think that we saw a pattern of things leveling out, but where the participation rate compares to the disenrollment rate I'd have to do a little more digging on that.

CHAIR THOMPSON: Melanie.

COMMISSIONER BELLA: The early work that CMS did, I mean, the retention rate is solid. And so it bears -- it makes the argument that if you can help people understand how to get in, once they get in they appear to be getting their needs met.

There is a high attrition rate in this population. There's a high death rate in this population. And so for states to keep track, to keep level, they have to keep enrolling. And many of them started with rounds of passive enrollment and they're not -- there aren't rounds of those people to make up for some of the involuntary disenrollment -- again, mostly due to death and other reasons. But I'd take the stability in there as a really good thing, meaning people must -- I would like to think it

means people are getting their needs met. I know there's a lot more complexity there.

COMMISSIONER SZILAGYI: Yeah, that's where I was heading, that if you take away the deaths, that if disenrollment is actually low then there's kind of a marker of quality.

CHAIR THOMPSON: Go ahead.

COMMISSIONER BURWELL: So I'm not as familiar with the duals demos as with other MLTSS initiatives linked with D-SNPs, and one of the states that we are working in very closely is Pennsylvania. And I just wonder, another major factor is just the amount of state investment in the enrollment process and stakeholder engagement and beneficiary engagement prior to the launch of the program. I know that that's a big factor. I know a lot of states kind of get behind, and, you know, a lot of things that they intended to happen prior to launch didn't happen, just because of things not going on schedule.

So in Pennsylvania, I know, you know, they started the enrollment process -- it is in three phases -- you know, Pittsburgh first, Philadelphia second, blah, blah, blah -- that one of the decisions -- lessons learned

from the first phase was you can never start too early, in terms of getting notices out. Stakeholder engagement with providers, you know, particularly, you can't do enough education.

And, I mean, I've also heard other anecdotes, you know, the issue with the enrollment broker. I know some states -- well, you know, they have MAXIMUS as their general Medicare enrollment broker. They added this on as a mod, but there wasn't any training on the phone. And I have heard anecdotal things, people calling up and the person on the other end saying, "No, I don't think that's a good idea," you know, like "don't enroll," you know. It's just kind of a complicated matter.

So, you know, there's a lot of -- I just -- you know, there's a lot of complexity, a lot of nuances around the factors that influence enrollment and disenrollment in these integrated care products.

MS. BLOM: Agreed.

CHAIR THOMPSON: Okay. I think this has been a very useful conversation and I do think that it's a very important topic.

I want to start someplace where Melanie was,

which is the idea that I think it's the general view of the Commission that integrated care models are good for the beneficiary, good for the program. And so the question of how do we design and promote those programs in a way that attracts beneficiaries and satisfies providers and produces, then, better health outcomes I think is the question that we're all asking ourselves.

I think there is a lot of interest, potentially, in pulling up more detail from the Mathematica report, because this is, you know, quite high level, and as you said, Kirstin, you know, it kind of validates people's impressions and certain other research that's been done, and I think that if we think we have some additional texture to add that would be useful in terms of an issue brief or something along those lines.

I think in terms of future directions I'm not sure I see a lot of traction on some of the ideas that you put on the table. Thank you for doing that, though. But I do hear interest in, you know, the enrollment experience, how to connect with providers and beneficiaries, how to understand local market conditions, which can include sort of what the available options are for beneficiaries there,

and what the incentives are for both providers and plans there, and, you know, Darin's issue on crossover claims.

I guess the question for us is, you know, how many of those subjects are really amenable to kind of research design or study that we could be doing? So I think that's the challenge, is really both in terms of understanding kind of where do we need to know more in order to be driving to the place that we all want to go, and how does that affect any kind of federal policy, on which we might have some recommendations, but also where is the evidentiary data that can help us think about some of those policy options?

So I think it might be helpful to kind of think about that and bring back to the Commission, later this spring, maybe a short conversation on that topic to help shape and refine expectations for next year's agenda.

MS. BLOM: That sounds good. We had been talking about coming back to you guys with like ideas for future direction based on, you know, feedback we would get in this conversation, so we'll definitely work on that.

CHAIR THOMPSON: And thanks as always, and thanks, Commissioners for that discussion.

All right. We'll go ahead and move on to the next topic, which is Physician Acceptance of New Medicaid Patients.

Okay, Martha, Kayla, thanks for being here, and take it whenever you're ready.

PHYSICIAN ACCEPTANCE OF NEW MEDICAID PATIENTS: NEW FINDINGS

* MS. HOLGASH: Thank you, and good afternoon, Commissioners.

In order to identify policies that are associated with physician acceptance of new Medicaid patients as a measure of physician participation in Medicaid, Martha and I directed the research project that I'm going to present now.

Previous research has examined multiple factors associated with provider participation in Medicaid and that has produced varying results, depending on the policy examined and the methods used. Our project took advantage of newer, post-ACA data that accounts for physicians of multiple specialties across all states as well state policies of interest.

We'll first provide some more background

information on our study, then describe our approach and the results found, leaving plenty of time for questions and discussion.

MACPAC contracted with the State Health Access Data Assistance Center at the University of Minnesota to analyze the National Ambulatory Medical Care Survey, or the NAMCS, which is fielded by the National Center for Health Statistics. The NAMCS collects data from a nationally representative sample of office-based physicians. We received authorization to use state-level data in our research, allowing us to group states together into categories of our choosing. However, we aren't able to report data on a state-by-state basis because the physician sample sizes were too small in many states.

We primarily used data from the 2014 and 2015 surveys, although we did use the 2012 and 2013 surveys to conduct a pre- and post-ACA comparison.

The NAMCS is structured to ask physicians if they accept any new patients and, if so, what payments sources they expect. We first compared acceptance rates of patients with Medicaid to those with Medicare and private insurance. Then we focused only on the sample of

physicians who accept new Medicaid patients.

Among the group of physicians who do accept new Medicaid patients, we examined state policies that we thought may be associated and whether the association varied based on their physician specialty. These policies included the level of managed care penetration in their state and whether the level is above or below the national average, their Medicaid expansion status, and the Medicaid payment rates relative to Medicare.

Before presenting our results we are required to state that these findings and conclusions are those of the authors and do not necessarily represent the views of the Research Data Center, the National Center for Health Statistics, or the Centers for Disease Control and Prevention.

So moving on to the results of our study. We compared, as I stated, the rates of physicians accepting new patients by insurance type and found that 70.8 percent of physicians accepted Medicaid, which is significantly lower than the 85.3 percent of physicians accepting new Medicare patients and the 90 percent accepting new patients with private insurance.

When looking by specialty, you can see here that family practitioners and psychiatrists are much less likely to accept new Medicaid patients than patients with Medicare or private insurance, and pediatricians are also less likely to accept new Medicaid patients than privately insured patients.

After comparing acceptance by insurance type we narrowed our focus to just the physicians who accept new Medicaid patients. Within this group, pediatricians, general surgeons, and OB/GYNs all accept Medicaid patients at a significantly higher rate than the total Medicaid acceptance rate, while psychiatrists accepted new Medicaid patients at a much lower rate than the overall rate, about 36 percent compared to that 70.8 percent.

Maintain our focus on just the physicians who accept new Medicaid patients, we looked at state-level policies that we thought might be associated with those acceptance rates. This table shows the comparison and acceptance of new Medicaid patients between states with Medicaid managed care penetration rates above versus below the median level of 69.5 percent.

Before controlling for confounding factors,

overall physician acceptance of new Medicaid patients was 66.7 in states that are above the median managed care penetration level. This is significantly less than the 78.5 percent of physicians in states that are below the median. This held true for general practitioners, general surgeons, and OB/GYNs, as indicated by the asterisks in the last column.

So, for example, the 90.3 percent of OB/GYNs, if you look at that fourth row down, in states with lower managed care, accepted new Medicaid patients, and that is significantly higher than the 75.4 percent of OB/GYNs taking new Medicaid patients in states with higher managed care penetration.

Acceptance rates for pediatricians and psychiatrists were not significantly different between states with high versus low managed care penetration.

The next state policy we examined was whether or not the state expanded Medicaid as of January 1, 2015. We looked at expansion status in two ways.

First, we looked at states that did not expand Medicaid and compared them to the states that did expand. There was no statistical difference in overall rates of

accepting new Medicaid patients, but for OB/GYNs acceptance rates were higher in non-expansion states.

Second, we looked at whether acceptance rates changed over time. We looked at just the expansion states and compared acceptance in 2012 and 2013 before they expanded to rates in 2014 and 2015 after they expanded. And then we did the same thing for the group of non-expansion states, comparing acceptance in 2012 and 2013 to 2014 and 2015. There were no significant differences in rates of accepting new Medicaid patients in either of these two groups.

Finally, we looked at state Medicaid payment rates relative to Medicare rates. The Urban Institute's Medicaid-to-Medicare fee-for-service fee index determined that the national Medicaid-to-Medicare payment ratio average in 2016 was 0.72, meaning that, on average, Medicaid pays 72 percent of what Medicare pays. As you can see in this table, we compared acceptance of new Medicaid patients in states that pay above that 0.72 median to acceptance in states that pay below that median. The states that paid above the median also had higher Medicaid acceptance rates than states that paid below that median.

So that's the top row, the 81.1 percent, compared to 64.5 percent. This was consistent for physicians in most specialties, including general practitioners and surgeons as well as OB/GYNs. There was no statistical difference in Medicaid acceptance rates for pediatricians or psychiatrists.

After completing that descriptive work, we conducted a multivariate analysis to test the magnitude of the association of those state policies with the rate of acceptance of new patients, new Medicaid patients, while controlling for the confounding factors that are listed on this slide.

So, for example, we asked: Do physicians in states with high managed care penetration still accept new Medicaid patients at a lower rate than those in states with lower managed care penetration once we controlled for the share of the population using Medicaid and a state's overall physician supply? And if so, how much lower are their rates?

What we found is that the marginal effects of managed care penetration were no longer statistically significant. Medicaid expansion likewise still did not

have a statistical association with Medicaid acceptance. The only policy that was associated with Medicaid acceptance was payment rates. When Medicaid fees were higher relative to Medicare rates, the likelihood of physicians accepting new Medicaid patients was also higher. Specifically, we estimated that within a state a one percentage point increase in the fee ratio would increase acceptance of new Medicaid patients by 0.78 percentage points.

And that is all. We look forward to your discussion of these findings and are happy to take any questions.

CHAIR THOMPSON: Very interesting. Okay. We're going to start off with Peter and then Sheldon.

COMMISSIONER SZILAGYI: Sure. Very nice job. Thanks. Let me start with a question. Where are internists in here? Are they included in the general and family practice? I'm talking about primary care internists.

MS. HOLGASH: The primary care, yes, there are --

COMMISSIONER SZILAGYI: Or was it hard to differentiate here?

MS. HOLGASH: So you mean all primary care physicians, which --

COMMISSIONER SZILAGYI: Internal medicine.

MS. HOLGASH: Just internal medicine specifically?

COMMISSIONER SZILAGYI: Yeah.

MS. HOLGASH: That's general and family --

COMMISSIONER SZILAGYI: That's just called general?

MS. HOLGASH: Yes.

COMMISSIONER SZILAGYI: Okay. So to me this is really helpful. On the ground -- I'm a primary care pediatrician. I practiced in two states -- one where payment rates were high and currently where payment rates are low. And this is, you know, as an anecdotal, in both my practices it was primarily Medicaid. In the practice where we had high payment rates, we had mental health people, social workers, outreach workers, nutritionists. We gave comprehensive care. In my current practice with low payment rates, we have none of that. And so even though I don't focus that much of my own work on payment rates, they do matter. And so I'm not surprised that the

findings, particularly the multivariate findings, which are really striking for a typical multivariate analysis, that payment rates affect accepting new Medicaid patients. And it goes along with what people who are on the ground seeing patients experience.

In the state where I am now, it's really difficult to find subspecialists to take care of Medicaid patients, even though the Medicaid coverage is very high. So it is really a factor, and so this kind of corroborates, you know, my experience.

Having said that, we have to keep in mind that accepting patients is only the first step and what we really care about is quality and outcomes. Obviously we cannot get that from NAMCS.

Just a couple other points. There was a recent study by the American Academy of Pediatrics last year that showed that the primary care bump in Medicaid resulted in between a three and a six percentage point increase in pediatricians accepting kids with Medicaid. So that was a totally different database. It wasn't NAMCS. It was an AAP provider survey, but it kind of corroborated this.

So I think this is helpful, and it corroborates

what people on the ground kind of know, that fee payments matter. And it was really also striking about the results with the mental health providers, with psychiatrists, and that goes along with people's experience on the ground as well.

MS. HOLGASH: I'm sorry. I just want to correct myself. There is a separate row for internal medicine.

COMMISSIONER SZILAGYI: If you can separate out internists who are primary care internists, you know, even if not, I would probably add that to the tables.

MS. HOLGASH: Thank you.

CHAIR THOMPSON: Sheldon.

COMMISSIONER RETCHIN: Well, thanks. First of all, this is great work. I've been waiting on this for a long time. I feel like maybe I was in junior high.

[Laughter.]

COMMISSIONER RETCHIN: But this is very helpful. A couple of points, and then I'm going to get around to something that I just -- I found this very alarming.

But, first, I didn't really understand. On Table 2, when it says -- when the column says "Accepts payments for new Medicaid," does that mean they -- they accept

Medicaid, right? It just sounded like, okay, we see Medicaid but we don't accept their payments. I didn't really understand why that qualification on the column.

MS. HOLGASH: I'm sorry. I want to make sure I'm in the correct -- you're talking about Table 2 in the memo, not the --

COMMISSIONER RETCHIN: Yeah, right. Right. So it says, "Accepts payments from new Medicaid patients." It means they accept new Medicaid patients, right?

MS. HOLGASH: So this table shows that -- shows the percentage of payments that are expected from Medicaid all together.

COMMISSIONER RETCHIN: Okay.

MS. HOLGASH: And this is just among the physicians that accept new Medicaid patients. So this isn't showing how much they expect to be paid from those new patients. It's showing that among physicians who accept any new patients, the ones that accept Medicaid, it asks the question: What percent of your overall practice payments are expected to be from Medicaid?

COMMISSIONER RETCHIN: I understand that on the first column. It's the declining percentages in the second

column that I found a little confusing. But maybe we could just go offline with that.

And then I do want to -- one cautionary methodologic note is that this is all based on 1,410 physicians. So as we get into some granularity, the confidence intervals are going to be pretty wide. That said, I had one important point, I think, from what I took -- I don't know about the other Commissioners. I found this very alarming in Table 1, that 65 percent of psychiatrists do not take new Medicaid patients. At a time when we've just expanded Medicaid, at a time when the nation is paralyzed by substance use disorder, mental health problems, I think this is cause for alarm. I don't know what action we should be taking, but if we see that, we can't tell whether this is leading to a significant barrier or access-to-care problem for this population. But it certainly suggests that's true.

And, in fact, if you look at the non-expansion states, that too has plummeted over the two year segments that you looked at. So it suggests that we have -- we knew we had a workforce shortage, but this is really impacting this population.

CHAIR THOMPSON: Toby and then Kit. Wait a second. Let me write this down. Hang on. I said Toby --

EXECUTIVE DIRECTOR SCHWARTZ: Toby, Kit.

CHAIR THOMPSON: -- Bill, Kisha, Darin, Kathy.

EXECUTIVE DIRECTOR SCHWARTZ: Fred.

CHAIR THOMPSON: Fred.

COMMISSIONER DOUGLAS: Great job and really informative. Just one question. Is there a way to be teasing out federally qualified health centers from this? Because it would be -- especially on Table 2, as well as Table 1, but really understanding how the variation between -- most of the Medicaid penetration for primary care within the FQHCs and then being able to see what is the private practice participating in it.

MS. HOLGASH: With this particular NAMCS survey, no, but there is a community health center separate survey that they collect as well.

COMMISSIONER DOUGLAS: So is there a way to bring the two together or to try to -- or is that just -- because it's the one missing piece, as well as over time is the access, you know, where is it coming from?

MS. HOLGASH: I would have to look into that

more, but I don't know initially.

CHAIR THOMPSON: Kit.

COMMISSIONER GORTON: So I'll add on to Toby's idea. At a broader level -- and I think there might be data in the NAMCS data set, but maybe not, about employment. So groups, employed physicians, private practice physicians, you know, in some cases these docs -- I never worked for myself. I never decided what patients I took or didn't take. Somebody else decided that. And so I do think there may be a dynamic that you could pull out of -- another variable that you could pull out of the NAMCS data that says, you know, private practice psychiatrists are not accepting very much by way of Medicaid, but, in fact, psychiatrists working in public hospitals, psychiatrists working in academic centers, those psychiatrists -- I mean, you go to those places and 100 percent of their patients are Medicaid. So I think that that might be a slice that is illuminating.

MS. HEBERLEIN: So, Kit, I just want to point out on Table 1 we did look at practice ownership. We did not look at it by like provider type, so it has in there physician or physician group, medical academic health

center, or an insurance company, so who owns the practice. But we didn't look at it psychiatrists --

CHAIR THOMPSON: We don't have the cross tabs.

MS. HEBERLEIN: Yes. No cross tabs. I was trying not to go methodologically. No cross tabs there. Sorry.

COMMISSIONER GORTON: But I think in this case cross tab might be informative.

MS. HEBERLEIN: Yes.

CHAIR THOMPSON: Bill.

COMMISSIONER SCANLON: Partly related to what Sheldon was bringing up, I feel like there's a story behind each one of the specialties that's different, and I think that's important to take into account. And I've been thinking about sort of the boundaries of the survey, potential sort of other types of professionals that might be providing services. It's not to feel reassured. It's just these things, there is more complexity to this. And to Peter's point, if we had people certified in internal medicine, that doesn't mean that we've got primary care physicians. We've got all kinds of subspecialties there. So there's that aspect of it.

I just wanted to -- I mean, and to add to that, sort of bringing this to the table on the differences in terms of managed care penetration, and to me there's a potential story there, which is “how are managed care plans managing physician access?”, and it actually -- they may sort of have strategies to say, "I'm going to deal with fewer physicians, get better response, than having it open to sort of everybody." And I don't know whether, to those of you who worked in managed care -- and I never have -- whether that's a strategy that's used, you know, and it could result in lower -- what seemingly are lower participation rates, but absolutely a deliberate strategy.

CHAIR THOMPSON: That was the sidebar Stacey and I were having as those numbers came up, while they're actively managing their network, kind of expect some of that.

Kisha?

COMMISSIONER DAVIS: Thank you. And not surprising, again, you know, just kind of being on the ground and seeing how this plays out in my own practice, the reason that our practice takes Medicaid is because in our state there was Medicaid-Medicare parity, and that was

a big financial business decision on whether or not we would take Medicaid. We're not an FQHC and so hence don't have that bump and that extra, you know, support that comes with reimbursement rates. And so when you think about private practices who aren't affiliated with community health centers, that, you know, financial model comes into play a lot, especially when you think about the added burden, as we talked about earlier, in terms of program integrity and all those other hoops that you have to jump through in terms of trying to provide care for Medicaid patients.

And so my question then becomes, you know, where do we go from here on this? Are there recommendations that we make? And, also, how does it play out then? Because you're starting to get this disparity, especially in primary care, for those states that have better coverage, better Medicare-Medicaid parity and states that don't. So how is that coming out on the ground? Are you starting to get access issues, especially for primary care? You know, what does that look like on the ground for beneficiaries, for patients?

CHAIR THOMPSON: I do want to come back to that

question of where does this take us and are there some specific things that we would like -- we're already suggesting some things of augmenting, at least for the purposes of an initial issue brief, but then beyond that, where do we want to take some of this as follow-up?

Darin?

COMMISSIONER GORDON: One of the things -- and it's not easy to collect from the data source, but, you know, as I think about it, particularly in terms of psychiatry, that tends to be a case in Medicaid -- at least in my experience this was an issue -- where it was required that in providing mental health services that you also offered case management services, which pretty much rules out just about every private psychiatrist. But all the community mental health centers were all in, so now that works.

And so there were some policy decisions that I think to some degree inhibit greater participation, particularly in that area, and I think Kentucky, if I recall correctly, did something to try to increase their participation of private psychiatrists in the Medicaid program, and I don't remember all the details, but I mean,

it was a difficult fight. But they were able to see much -- significant gains in participation after making some changes, but it may be worth looking at because that is an area where -- I mean, significant outlier as compared to the other specialties we list.

CHAIR THOMPSON: Let's see. I have Kathy, Fred, Martha, and then, Leanna -- oh, Chuck -- and then, Leanna, I would like for you to jump into this conversation.

COMMISSIONER GEORGE: Yes [off microphone].

CHAIR THOMPSON: Okay, good. I've got you on the list then. All right. So, Kathy?

COMMISSIONER WENO: Most of the comments have already been asked that I was going to bring up. I would just, as the resident dentist, also like to say that 60 percent acceptance rate would be great in any state for dental. But on the other hand, too, I also -- when you're looking especially like in frontier communities where people are accessing care, most of them are at rural health clinics seeing nurse practitioners. And in order to really look -- if that's the question, you know, are we looking at access to primary care, we can't ignore a lot of these other providers. And if there's a way to get at that, I

think that's really the question we should be asking.

CHAIR THOMPSON: Fred.

COMMISSIONER CERISE: On the psychiatry issue, actually, Sheldon, where I thought you were going to go that you're really worried about was not the 35 percent acceptance but the 60 percent acceptance on Medicare and private insurance as well, because that just is worrisome to me. I think it just says something about psychiatry, you know, that we just tend not to value it, and you see it show up across the board. It's the lowest in Medicaid, but everything's the lowest in Medicaid. Not that that's good, but it's so much lower in the other areas as well. And if we haven't addressed that on a broader scheme by Medicaid, it's going to -- it takes it the hardest, you know? And so that is particularly worrisome to me.

The other comment I'll make is around the larger institutions, whether it's academic health centers, community health centers: the places that have other sources of supplemental income to do this work. So it kind of makes sense that they can do this because you're getting some boost, and just sort of, it kind of confirms what you're showing, that is, it's the money available to do it

that's driving participation.

CHAIR THOMPSON: Martha.

COMMISSIONER CARTER: Two points. I want to reiterate what Kathy said that in a lot of rural communities that primary care in particular is being provided by nurse practitioners and PAs, so that has to factor in here somewhere.

I hesitate to say this, but this is current anecdotal information because I saw this startling statistic on psychiatry and asked our employed psychiatrist the other day what's up with this. Something that I learned that I didn't know was that the residency programs have actually, until recently, had a hard time filling their slots. So we weren't generating enough psychiatrist to begin with.

The psychiatrists right now are making very high salaries because there's a national shortage of psychiatrists, and you look at HPSA scores, mental health HPSA scores across the country, it's quite high. So it all factors in.

I only have this one conversation to go on. He said that there's now a bit more of a resurgence in people

being interested in going into psychiatry. So the residency programs are more able to fill their slots, but we're living with that legacy.

CHAIR THOMPSON: Chuck.

COMMISSIONER CARTER: So that the thought, why did people want to go into psychiatry, and it's probably connected to payment rates.

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: My apologies. I was out for a work call, and it's always dangerous to come in three-quarters of the way through the movie, but why not?

[Laughter.]

CHAIR THOMPSON: One of the things, when I read the materials ahead of time, the managed care penetration, it was surprising me that it was lower. But one of the things that I do want to just contextualize about that is that simultaneous with a lot of the Medicaid enrollment growth and the access issues that that presents, there's also a very strong push, as we've talked about here, about value-based contracting and paying for value and not volume. From a managed care organizational point of view, having a lot more scale at a given provider creates more

opportunities to do interesting shared savings models or capitation models, or it gives them scale to then get social workers or outreach workers to do HEDIS gaps in care. It gives them more scale to do other kinds of things with peer support specialists and otherwise.

I know that the materials have said this, and I'm guessing you said this before I got here. There are a lot of ways of angling in, triangulating in on access. Participation rates is one of them. Time during appointment is one of them. Time and distance is one of them. Call center or member service complaints is one of them, all of those kinds of things.

But the point I want to make here is having 100 percent participation where a lot of providers have small panels kind of works against some of the value-based contracting goals that we also have. So I just want to contextualize it that way.

CHAIR THOMPSON: Leanna, I'm going to let you have the last word before we wrap up.

COMMISSIONER GEORGE: I have also had my challenges with psychiatry and psychological services for my kids. In fact, it's one of the services that we needed

to have lined up to pull Serenity out of a residential center. So instead of being able to bring her home, we're spending more money keeping her institutionalized for a longer period of time, all because we couldn't find a psychologist.

Also, when looking for services for my son, Caleb, I'm making phone calls, not getting call-backs, even though they advertising providing services to Medicaid patients.

So you've got to question or wonder is that even really an accurate number when they're not returning our calls back.

I also want to comment on university centers and larger health centers is that sometimes these waiting lists to get in to be seen by them might be six, eight, nine months, and you're wanting an answer a little bit sooner than that.

CHAIR THOMPSON: Thank you.

Well, Martha, Kayla, obviously a lot of interest in this. We know that you're seeking publication, which we are supportive of and hope you're successful at.

I think there's also been a fair amount of good

ideas here for thinking about expanding, even with publication, on an issue brief with some additional information.

I do think that we ought to, as with the last session, think about where this takes us, picking up on -- I think it was Kisha making that initial point -- and maybe thinking about some of the areas where we want to dive deeper, whether it is psychiatry or some of the other areas where we want to understand a little bit more about workforce dynamics, supply.

It's unclear how much of that is stuff that -- I mean, payment policy is something Medicaid agencies can do something about. Workforce and supply, they can have some impact on, but maybe not so direct. So maybe there's some thinking that we ought to be doing about trying to pull that apart and identify the places where we think there could be some more direct Medicaid action.

I seem to remember -- this is always dangerous pulling it out of the recesses of memory. I can't remember if it was when we were looking at the Access Monitoring Plans or when we were looking at some of the regulatory issues. We were talking about this idea that if a state

paid at a Medicaid rate or within some parameter of a Medicaid rate, maybe that would be one way of releasing them from having to do a lot more reporting or review.

I don't know if this takes us in that kind of a direction, where we could make that kind of a recommendation, where we would say maybe this is one way that we ought to be scrutinizing access, availability and access, which is really looking at the top level at payment rates, which seem to be the big driver, and then focusing on those areas of the country where the payment rates are substantially below Medicare and asking ourselves what's going on there and what compensations can be made and whether or not agencies are fulfilling their responsibilities to provide adequate access to care.

So maybe that's something we could give some thought to as well.

Okay. Let me stop here and ask for public comment.

PUBLIC COMMENT

* MR. HALL: Hi. I'm Bob Hall, and I'm the director of Government Relations for the American Academy of Family Physicians. Thanks for looking at access to care

for patients and access to physicians in Medicaid.

I'd like to talk about Medicaid block grants, which I believe, if implemented widely, would actually further harm access to Medicaid services.

The AAFP represents 131,400 physicians and student members nationwide. Family physicians conducted approximately one in five office visits in the United States, which is 192 million visits annually.

Today, family physicians provide the majority of care for America's underserved rural and urban populations, and according to AAFP surveys, family physicians in particular in rural areas care for more Medicaid patients than private-pay patients. So this is the back bone of primary care in the United States.

We've recently been elected as the first co-chair for the Partnership for Medicaid, which is a nonpartisan nationwide coalition of 23 organizations representing doctors, health care providers, safety net health plans, and counties and labor. The goal of the coalition is to preserve and improve the Medicaid program.

We've recently come up last year with some updated principles on Medicaid. I'll read three of them to

you now. There are 12.

First, proposals to reform Medicaid should balance state flexibility and innovation with necessary federal standards to protect patients.

Second, recognizing the countercyclical nature of the program, any reform should strengthen the ability of Medicaid to provide coverage during an economic slowdown.

And, third, Medicaid reform must avoid shifting costs onto states, local governments, providers, and beneficiaries. I think all three of those apply in that context of Medicaid block grants.

But let me take off the hat for Partnership for Medicaid for a second and even for AAFP.

I personally have never seen a block grant proposal that would confirm to either the partnership's principles or the idea that we need to keep Medicaid strong.

I'm alarmed that this zombie policy keeps coming up, and I think there's very strong reasons why it should be rejected.

Medicaid block grants are bad for a host of reasons. I'd like to elevate something that Bruce Lesley

recently wrote. He's a long-term advocate for children in the community. He gives 10 reasons why block grants are bad.

First, they underfund the health care system. Look at Puerto Rico. Puerto Rico is languishing at this point with its Medicaid financing. Fail to adjust for natural disasters. Block grants also fail to adjust for economic recessions, demographic changes, public health crises. They fail to adjust for costs associated with medical breakthroughs or cures. Block grants pit groups within the Medicaid program against one another. They also put pressure on other state programs and services, and if they are done by a waiver, they can lead to political abuse. And, finally, we really do believe that block grants would undermine the guarantee of coverage that folks experience within Medicaid right now.

Thanks very much for everything you do, and thanks a lot for listening.

CHAIR THOMPSON: Thank you.

Okay. Martha, Kayla, any other questions, comments in response to our conversation that you'd like to make before we move on?

MS. HOLGASH: No. Thank you.

CHAIR THOMPSON: Okay. So I'm going to do a little bit of a time check here. We are at 2:15. We did have a break scheduled, but what comes next are votes on the discussions that we had this morning on UPL and DSH. So I would like to use my prerogative to move directly to those votes without taking a break, and then we'll just be done all the sooner.

All right. So what I'm going to suggest, appreciating what might take longer versus shorter, is start with the UPL recommendations, and then we will move on to DSH. We may do DSH In reverse alphabetical order.

All right. So what I want to do is Rob will show us the revised recommendations. We will have an opportunity for Commissioners to ask any questions on the recommendations that Rob needs to answer, and then we will move to a vote.

I want to just reinforce that because this is a voting meeting. Our conflict of interest rules apply. Those policies for the public are posted on the MACPAC website.

Under our policy, a reportable interest has to be

particularly, directly, predictably, and significantly affected by the outcome of a vote on a specific recommendation. It is not a generalized interest.

On November 19th, the MACPAC Conflict of Interest Committee chaired by Stacey, met by conference call and determined for the purposes of our vote today on both UPL and DSH that under that standard, no Commissioner has an interest that presents a potential or actual conflict of interest, and therefore, no Commissioner will be recused from the vote by virtue of the Conflict of Interest Committee. Of course, any Commissioner can abstain or recuse themselves from any vote as they so choose.

Okay. So, Rob, take it from you.

VOTES ON HOSPITAL PAYMENT RECOMMENDATIONS FOR MARCH REPORT

* MR. NELB: Great. So come back to our UPL recommendations, again, we have two recommendations that we're anticipating will be voted on as a package.

The first is the same as I presented earlier: The Secretary of the U.S. Department of Health and Human Services should establish process controls to ensure that annual hospital upper payment limit demonstrate data are

accurate and complete, and that the limits calculated with these data are used in the review of claimed expenditures.

The second recommendation, we made the small tweak to add "hospital-specific" in terms of the data. The full recommendation reads as follows: To help inform development of payment methods that promote efficiency and economy, the Secretary of the U.S. Department of Health and Human Services should make hospital-specific upper payment demonstration data and methods publicly available in a standard format that enables analysis.

CHAIR THOMPSON: Okay. Those should look familiar.

MR. NELB: Yeah.

CHAIR THOMPSON: So any questions from the Commissioners before we move on to our votes?

[No response.]

CHAIR THOMPSON: Okay. Anne.

EXECUTIVE DIRECTOR SCHWARTZ: I can't read backwards, so I'm going to start at the top.

CHAIR THOMPSON: Yeah. I was going to suggest that.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. So for

Commissioners, you can vote yes, no, or abstain.

Melanie Bella.

[No response.]

EXECUTIVE DIRECTOR SCHWARTZ: Oh, she stepped out. I'll come back.

Brian Burwell.

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter.

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise.

COMMISSIONER CERISE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis.

COMMISSIONER DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas.

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George.

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon.

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton.

COMMISSIONER GORTON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin.

VICE CHAIR LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan.

COMMISSIONER MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin.

COMMISSIONER RETCHIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon.

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi.

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Alan Weil.

COMMISSIONER WEIL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno.

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Melanie came back. Melanie Bella.

COMMISSIONER BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: And Penny Thompson.

CHAIR THOMPSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. So that's 17 voting yes.

Thank you.

CHAIR THOMPSON: Good.

Okay. We will go on to DSH. I think we're fine on time. Yeah. So you can go ahead and show those to us, Rob.

MR. NELB: Great. Again, we have three DSH recommendations. The first one is where we made the change, adding the preamble Alan mentioned. So the revised recommendation reads as follows: If Congress chooses to proceed with disproportionate share hospital allotment reductions in current law, Congress should revise Section 1923 of the Social Security Act to change the schedule of DSH allotment reductions to $2 billion in FY 2020, $4 billion in FY 2021, $6 billion in FY 2022, and $8 billion a year in FY 2023 through 2029 in order to phase in DSH allotment reductions more gradually without increasing federal spending.

The text for Recommendation 2 is the same: In order to minimize the effects of disproportionate share hospital reductions on hospitals that currently receive DSH payments, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to apply reductions to states with DSH allotments that are projected to be

unspent before applying reductions to other states.

And last but not least, Recommendation 3 reads: In order to reduce the wide variation in state disproportionate share hospital allotments based on historical DSH spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to develop a methodology to distribute reductions in a way that gradually improves the relationship between DSH allotments and the number of non-elderly, low-income individuals in a state after adjusting for differences in hospital costs in different geographic areas.

CHAIR THOMPSON: All right. Thank you.

Okay. As before, we will go around with votes after giving Commissioners an opportunity to ask any questions on the recommendations.

Darin.

COMMISSIONER GORDON: Can I ask a clarifying question regarding one of the tables in the actual write-up, just so I'm making sure that I'm understand that in the context of --

CHAIR THOMPSON: Sure, sure. Whatever you need

to be able to cast your vote.

COMMISSIONER GORDON: Table 1-2, aggregate percent change in DSH allotments under various scenarios, fiscal year 2023.

CHAIR THOMPSON: Just so we're following along, hang on.

EXECUTIVE DIRECTOR SCHWARTZ: Fourteen.

CHAIR THOMPSON: Thank you.

COMMISSIONER GORDON: Yes. Thank you.

So status quo is under the current reduction methodology that we see today, which is the expansion states would see a reduction in aggregate as a collective, a 61 percent reduction. Non-expansion states would see a 50 percent reduction. Is that --

MR. NELB: That's right, in the aggregate.

COMMISSIONER GORDON: And so under Recommendation 3, that would change to where expansion states would, in essence -- in aggregate, again, understand there are differences within the states -- a reduced reduction by about 2 percentages points to negative 59 percent, and then in non-expansion states they would basically see a greater reduction, by about 5 percentage points, to negative 55

percent. I'm reading that -- I'm interpreting that all correctly.

MR. NELB: Yeah. Again, yeah, this is in the aggregate and so some do better or worse, but that's the total.

COMMISSIONER GORDON: But, in total, the aggregate for all combined, you should keep at the budget neutral, at the negative 57 percent. Gotcha. Okay. Thank you.

CHAIR THOMPSON: Sheldon, you have a question?

COMMISSIONER RETCHIN: I have a question. I'm sure we've been shown this. Do you know, roughly, Rob, the distribution of low- and high-DSH states with expansion and non-expansion?

EXECUTIVE DIRECTOR SCHWARTZ: He has them tattooed.

[Laughter.]

COMMISSIONER RETCHIN: I don't want to see that.

[Laughter.]

MR. NELB: Let's see. There are 17 low-DSH states, which were those that spent less than 3 percent of their DSH allotment -- Medicaid spending on DSH in 2000. I

mean, if you -- so I'm not sure I have the low-DSH list in front of me, but if you looked at Figure 1-3 on page 19, the ones that are shaded as having DSH allotments below 50 percent of the averages, you can see there, and, you know, it's a mix of expansion and non-expansion states. So that might help explain that.

But yeah, some of the -- yeah, so the policy we have is independent of whether states expand or not, but there are other factors which might, you know, some expansion states may be low-DSH or high-DSH. There are other factors that are --in the proposed methodology, those are the factors that drive whether or not a state has a large cut or not.

CHAIR THOMPSON: Okay. Chuck has a question.

COMMISSIONER MILLIGAN: Just -- I'm going to Table 1.1, Rob, so it's page 13. And I just, from the conversation in the morning, does this show that the number of uninsured individuals is more highly correlated to uncompensated care than the number of low-income individuals?

MR. NELB: It -- well, first of all, no measure is perfected correlated --

COMMISSIONER MILLIGAN: Right.

MR. NELB: -- and so I think measures, we would -- I think we characterized in the chapter as being moderately correlated. So that's a caveat.

I think what Table 1-1 shows is that the number of uninsured individuals is most correlated to uncompensated care for uninsured individuals, which is the Medicaid Cost Report definition.

COMMISSIONER MILLIGAN: Yeah.

MR. NELB: When you look at uncompensated for both Medicaid and uninsured individuals, so including the Medicaid shortfall, which is part of the current definition, the two measures basically have the same correlation. So that's --

COMMISSIONER MILLIGAN: Statistically insignificant difference?

MR. NELB: Right. Yep. We didn't do a formal statistical test but the numbers, 0.68 versus 0.67, are basically the same.

COMMISSIONER MILLIGAN: Thank you.

CHAIR THOMPSON: Okay. Any other questions. Fred.

COMMISSIONER CERISE: Can you clarify that point for me a little bit further? So the difference between those two columns is the Medicaid Cost Report is strictly based on uncompensated care, based on uninsured, and the deemed one includes Medicaid shortfall. Is that what you --

MR. NELB: Pretty much. Yeah. So it's charity care and bad debt is what the definition for Medicare Cost Reports, whereas the DSH audits includes Medicaid shortfall.

COMMISSIONER CERISE: And is that limited to correlation for deemed hospitals? So you've only captured deemed hospitals in there?

MR. NELB: Correct. We wanted to do sort of apples-to-apples between states, because some distribute DSH to all hospitals in the state and some just to a share. So we looked at the ones that are -- that served, again, the highest share of Medicaid in low-income patients, the ones that are required to receive DSH payments, which it's sort of a consistent group across states. And then for those we looked at the uncompensated care reported on the DSH audits, and that's where we found that both uninsured

and non-elderly low-income kind of both had the best relationship to that factor.

COMMISSIONER CERISE: Would you necessarily expect the same thing if you did it for all of the hospitals, or would you expect it to be kind of -- you know, would it be closer to that middle column if you tried to do that for all hospitals?

MR. NELB: I think so. It's a challenge because we don't have data on Medicaid shortfall for all hospitals. But I think, in theory, the concept, low-income -- non-elderly, low-income represents people that are both uninsured as well as people who are enrolled in Medicaid. So it's a measure that kind of captures both Medicaid and uninsured, at some level, whereas the number of uninsured individuals is obviously just people who don't have insurance.

CHAIR THOMPSON: Okay. Can we throw up the first recommendation? Anne just wants to make an editorial change.

EXECUTIVE DIRECTOR SCHWARTZ: I'm having a grandma moment here, that Rob and I talked about before. And I apologize because I'm not modeling good behavior, but

we had talked at lunch about changing the second Congress to "it," and I just don't want to set a precedent of ever changing a word that you are going to vote on. So is every -- what I would like to suggest is the first clause remain as it is but the "after current law," comma, it should say "it," and "it" clearly refers to Congress. I've just been having a problem with --

CHAIR THOMPSON: I noticed that too, Anne --

EXECUTIVE DIRECTOR SCHWARTZ: Congress -- two Congresses in one sentence. The staff is all laughing. Is that okay?

CHAIR THOMPSON: Accepted.

EXECUTIVE DIRECTOR SCHWARTZ: Okay.

CHAIR THOMPSON: Okay. We're going to go ahead and move to vote. My comments from earlier about conflict of interest applies well here. I will encourage Commissioners, in addition to voting, given the length and complexity of our conversations over a period of many sessions, I invite you to make commentary if you would like, on your rationale or your reservations. Please be relatively concise.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. And once

again you can vote yes, no, or abstain.

Melanie Bella.

COMMISSIONER BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell.

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter.

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise.

COMMISSIONER CERISE: Yes. I would like to comment, in that is I'm voting yes because this is an incredible improvement from the baseline of 1992 standard. I still do have some reservations about the relative correlation between uninsured and low-income, non-elderly, but on balance I'm comfortable with the recommendation and am voting yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis.

COMMISSIONER DAVIS: Yes, and I do want to express support for the definition of non-elderly and low-income.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas.

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George.

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon.

COMMISSIONER GORDON: I am going to explain why before I give my vote, which everyone should guess this, but I do like the first two recommendations. I really do. But since we're voting en bloc therein lies the challenge for me, because one of the offsets for coverage expansion was into the reduction in DSH. And as you helped clarify for me -- and again, I do agree; 1992 is not the perfect science for how things should be done, so I'm not advocating for that.

The concern I have is where states are accessing the additional federal funding for coverage, we would -- let me say it a different way -- states that aren't accessing the additional financial participation that comes with increased coverage of expansion would be taking, en bloc, a larger reduction with us using low-income individuals, while it would improve the position of expansion states. Again, I'm not saying the starting point is a good one or a bad one. It's just that concept is problematic for me. As a result, I'm going to vote no.

EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton.

COMMISSIONER GORTON: Yes, and I'm supportive of the low-income, non-elderly, with all due respect to my colleagues who went in different places to challenging choice between imperfect metrics. For me, it's -- the low-income, non-elderly addresses the original problems with the 1992, because what you're doing is you're starting -- the metric is really about people who have, or states that have low DSH allotments per low-income, non-elderly populations. So it's the ratio that matters, and for me that the gain against the 1992 methodology offsets the issues that Darin and others have so articulately outlined.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin.

VICE CHAIR LAMPKIN: Yeah, I support all three recommendations, so I'm going to vote yes. I would say that, in particular, with Recommendation 3, while I was originally, and still do have a little bit of a preference for uninsured as the metric rather than low-income, non-elderly, I actually feel like some of the clarification we got this morning took a lot of the pressure off that metric for me, in terms of our posture of setting a target based on need and driving towards that target, not locking that target or that metric in forever but really using this

opportunity to move away from an antiquated allocation that has no correlation with need to one that has a much stronger correlation with need. So I fully support the slate of recommendations, yes.

EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan.

COMMISSIONER MILLIGAN: I'm going to vote yes. A couple of comments. I want to completely align myself with what Fred said. My preference would be uninsured, but I do think this is vast improvement, and so on balance I'm supportive of this for that reason.

The second comment I want to make is kind of my pride of being part of this group, having this kind of conversation at an analytic, thoughtful, data-based kind of way. I'm mindful of the comment that was made right before this vote session started about block grants and zombie stuff. There will come a time, I think, when MACPAC is asked to make really complicated, formula-based decisions about another form of block grant besides DSH, and I think we've modeled good behavior here.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin.

COMMISSIONER RETCHIN: Caught on the zombie thing. We'll catch you after the -- figure that out.

I'm going to vote yes, but I do want to make one comment, that we actually didn't discuss the reformation of DSH, and returning back to discussions around global payment, that Rob had actually mentioned during previous sessions.

So while I vote yes, it is with grave concern over the size and rapidity of the DSH cuts, and I think I would just ask that the Commission return to this, because we've heard expressions of concern about non-expansion states. I have concerns as well about expansion states, that these cuts, we really do need to ensure, or at least examine the effects on access, rural hospitals, and vulnerable populations.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon.

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi.

COMMISSIONER SZILAGYI: I'm voting yes and just a quick comment. I do support basing the rebasing on the non-elderly, low-income individuals, although I'm also troubled by the same issues about the uninsured that Chuck and many others brought up. And in my own twisted academic brain I was trying to think of some sort of combination or

formula in which we would base it mostly on low-income but take into consideration. But in the big picture, for the long-term health of Medicaid and DSH, I think this is the right decision, so I vote yes.

EXECUTIVE DIRECTOR SCHWARTZ: Alan Weil.

COMMISSIONER WEIL: I'll vote yes and just say that if we thought this was hard, wait until we start talking about within-state allocation.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno.

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: And Penny Thompson.

CHAIR THOMPSON: Yes, and I do want to just make two comments. One is I do think that the discussions that we've had earlier about making sure that we recognize and that our public comments heard from recognize the significance of these reductions and the impacts on hospitals across the country, and call attention to that.

And I also recognize that no formula is perfect, and I do support the approach that we've outlined in this recommendation, but appreciate the arguments of the other Commissioners, and so I also want to echo Chuck's comments about appreciating the thoughtful, deliberate, and

analytical approach of all of the Commissioners. And, Rob, I want to especially thank you for your patience with us in going over territory again and again, and I thank the members of the public who have commented and contributed to this discussion as well.

EXECUTIVE DIRECTOR SCHWARTZ: It's recorded as 16 yesses and 1 no, and that will go in the report.

CHAIR THOMPSON: All right. Great job today, Commissioners, Commission staff. Thank you very much. We will adjourn -- Brian.

COMMISSIONER BURWELL: We will have an Executive Session tomorrow morning?

CHAIR THOMPSON: Yes, we will.

COMMISSIONER BURWELL: I do want to talk about Puerto Rico a little bit at this meeting.

CHAIR THOMPSON: Okay.

Okay. All right. We will see each other in the morning for Executive Session before we have our half-day session tomorrow, and we are adjourned.

* [Whereupon, at 2:40 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, January 25, 2019.]

PUBLIC MEETING

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

Friday, January 25, 2019
9:10 a.m.

COMMISSIONERS PRESENT:

PENNY THOMPSON, MPA, Chair
STACEY LAMPKIN, FSA, MAAA, MPA, Vice Chair
MELANIE BELLA, MBA
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
FRED CERISE, MD, MPH
KISHA DAVIS, MD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
DARIN GORDON
CHRISTOPHER GORTON, MD, MHSA
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
WILLIAM SCANLON, PhD
PETER SZILAGYI, MD, MPH
ALAN WEIL, JD, MPP
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:10 a.m.]

CHAIR THOMPSON: Okay. Why don't we go ahead and get started. Welcome, everyone. We're very excited this morning to have a panel of really great experts to help us through understanding utilization management of medication-assisted treatment, a very important topic for us.

Nevena has been leading the charge for MACPAC on this subject and has arranged this great panel for us this morning. As our usual practice, what we will do is have our panelists speak and an opportunity for Commissioners to ask questions to understand the subject further. We'll have an opportunity for public comment after the end of the panel. We will then reconvene and have some crosstalk among the Commissioners with Nevena in terms of thinking about the implications of what we've heard for our ongoing work and how we want to embed some of what we've learned into that.

With that, I will ask Nevena to introduce our panelists and get us kicked off.

PANEL: UTILIZATION MANAGEMENT OF MEDICATION-ASSISTED TREATMENT

* MS. MINOR: Hi. Good morning.

Today's panel follows previous Commission discussions and reports to Congress on the opioid epidemic in which you identify the need for increased access to medication-assisted treatment.

You expressed an interest in better understanding how various Medicaid coverage policies affect availability and utilization and other policies, such as preferred drug status and ones that require counseling in combination with office-based medication therapy.

The SUPPORT for Patients and Communities Act, the federal opioids bill that was enacted last October, also requires MACPAC to conduct a study of Medicaid utilization control policies for MAT that may hinder or promote access to clinically appropriate treatment.

I'll go over the study components at the outset of the next session, and you have more detailed information in your meeting materials.

To help inform your ongoing work and the study, we've invited three experts to discuss how utilization management policies are applied to MAT and Medicaid.

First up is Dr. Anika Alvanzo, who is the Medical

Director of Johns Hopkins Substance Use Disorders Consultation Service and an assistant professor in the Division of General Internal Medicine. She will discuss her experience with Medicaid utilization management policies and how various approaches affect provider's ability to deliver evidence-based care, including MAT.

Our second speaker is Dr. Kristin Hoover, who is the Clinical Pharmacy Manager for Pennsylvania's Medicaid program. She develops and implements clinical programs in fee-for-service and oversees the drug benefits provided by contracted Medicaid managed care organizations in the Commonwealth. Dr. Hoover will discuss Pennsylvania's approach to managing their MAT benefits, such as the rationale for recently eliminating prior authorization requirements for certain MAT medications as well as instituting daily dose limits.

And our third panelist is Dr. San Bartolome, Medical Director of Substance Use Disorders at Molina Healthcare. He focuses on efforts to improve the organization's policy, organization's ability to address member needs related to substance use and integrating behavioral and physical health care. Dr. San Bartolome

will discuss Molina's approach to managing their Medicaid MAT benefit and will also provide information on how those approaches may differ depending on individual state Medicaid agencies' contractual requirements.

* DR. ALVANZO: Good morning, everyone. I'm Dr. Anika Alvanzo. I'd like to thank you for the opportunity to speak with you about the importance of access to quality evidence-based addiction treatment and share my experiences treating opioid use disorder as a Medicaid provider in Maryland.

As we all know, our country is in the midst of an opioid overdose crisis, with tens of thousands of Americans dying each year from opioid-related overdoses. In Maryland alone, more than 2,000 people died from drug overdose in 2017, a 9 percent increase from 2016.

Before I address utilization management policies, I wanted to first frame my comments by defining addiction and giving a very brief overview of what we know about medications for addiction treatment with a focus on the three FDA-approved medications for treatment of opioid use disorder.

Addiction is a chronic brain disease

characterized by continued use, despite associated psychosocial, medical, and interpersonal consequences. As with other chronic diseases, addiction is often marked by cycles of remission and recurrence, and when untreated can be progressive, resulting in premature disability or death.

Despite the devastating effects of untreated addiction, only a minority of those with substance use disorder, including opioid use disorder, report receiving treatment. This slide looks specifically at treatment in specialty facilities or private doctors' offices.

There's substantial evidence supporting the clinical effectiveness of the use of the FDA-approved medications in combination with evidence-based medical, behavioral, and social supports for the treatment of opioid use disorder.

Currently, there are three medications that are FDA-approved for use in treating opioid use disorder: methadone, buprenorphine, and naltrexone. The pharmacology formulations, DEA scheduling, and regulations are different for each of these medications, but the decision to use a particular medication is a decision that must be made between a patient and his or her medical practitioner based

upon the patient's diagnosis, unique biopsychosocial circumstances, and treatment goals.

In addition to medications, for some patients, behavioral therapies are also essential in their treatment and recovery. These therapies may include things like motivational enhancement, cognitive behavioral therapy and skills training, contingency management in which you incentivize behavior such as counseling attendance or provision of drug-negative urines.

In addition, recovery supports might consist of peer-to-peer support or coaching, housing, employment services, among others.

However, it should be noted that there are also patients who can be managed in an office-based setting with medical management alone.

Multiple studies have demonstrated the effectiveness of medications for the treatment of opioid use disorder and reducing opiate use and increasing treatment retention. However, the benefits of medication are not isolated to substance use and treatment outcomes. Most notably, the agonist pharmacotherapies are associated with significant reductions in mortality, increases in

employment, decreases in criminal activity, and decreased risk for HIV and hepatitis C transmission.

Although the evidence regarding effective treatment regimens for opioid use disorder are well established, patients, physicians, and other practitioners continue to face barriers imposed by insurers in the form of utilization management techniques that improperly delay or at times deny care. Prior authorization, step therapy, fail first, duration, and quantity limits have all been deployed in Medicaid programs to regulate the provision of care.

From my perspective as a clinician, one of the most concerning are duration limits. We know that addiction is a chronic disease. However, in some instances Medicaid insurers have put limits on the amount of time that a patient is able to be on medication.

Additionally, prior authorization requirements are one of the greatest barriers to care, often delaying initiation of evidence-based addiction treatment.

In July 2016, the Maryland Medicaid Pharmacy Program made the decision to restrict the formulary to one formulation of buprenorphine, requiring prior authorization

for all others. For many patients who have been stable and become accustomed to another formulation, this resulted in a need to change to the preferred formulation, despite the fact that the previous formulation was working for them. This for many patients was clinically disruptive.

For practitioners and their staff, this meant spending countless hours on paperwork and electronic authorization forms rather than focusing on provision of patient care.

To give you another example of how prior authorization requirements impact medical practices, I have some colleagues who have even hired a dedicated staff member to focus exclusively on processing prior authorization requests.

Fortunately, thanks to successful advocacy efforts in Maryland, Maryland removed the prior authorization requirement for the different formulations of buprenorphine the following year.

As physician, I understand that there are rightfully some concerns about diversion and the need to structure proper controls to combat it. However, insurers, including Medicaid, wrongly assume that utilization of

management techniques, such as prior authorization, successfully combat diversion. Prior authorization, as mentioned before, result in treatment delays, and delayed treatment may in fact exacerbate diversion. The longer patients are without clinically recommended treatment due to delays in commencing or continuing treatment increases the likelihood that they may choose to either forego treatment entirely or seek access to an alternative pathway to treatment in the interim, such as using medications provided by family members, friends, or other acquaintances.

Given that many individuals cite the lack of access to addiction treatment as a reason for diverting medications, one of the most important things that insurers can do is to promote policies that control diversion by enacting and continuing policies that increase access to evidence-based care. The use of prior authorizations for medications to treat opioid use disorder is not the best way to manage diversion.

Additionally, some insurers require that physicians and other clinicians include documentation within the prior authorization request about receipt of

referrals to counseling by someone other than the prescriber of the medication for opiate use disorder.

As a physician working in an opiate treatment program, I believe strongly that many patients do indeed benefit from behavioral support services such as counseling by behavioral health specialists. However, this does not apply to all patients. There are patients who can be managed safely in an office-based setting with medical management alone. In fact, there have been several randomized clinical trials that have shown no additional benefit of counseling over medication management in office-based buprenorphine settings.

If a patient needs behavioral support services, then they should absolutely receive them without delay. However, the notion that insurers would require physicians to document the receipt of a service that some patients may not need is a departure from the doctor-patient relationship.

In closing, let me restate what we already know. Thousands, tens of thousands of Americans are dying each year from opiate overdoses. It is critical that we ensure that those suffering from the chronic disease of addiction

have necessary access to evidence-based treatment by expanding its access. While I understand that Medicaid uses utilization management tools to control cost and guard against improper utilization, all utilization management tools should be evidence based and must ensure that they do not inadvertently limit access to evidence-based treatment.

Maryland's Medicaid program has made important steps toward achieving that goal, but we all still have work to do.

I thank you for your time, and with that, I will cede to my other panelists and take questions at the end.

And for more information, we have the ASAM National Practice Guideline as a reference for you.

* DR. HOOVER: Good morning. My name is Kristin Hoover. I'm from Pennsylvania Medicaid.

And to begin, I'd just like to give you a quick snapshot of the Medicaid program in Pennsylvania. As of October 2018, Pennsylvania had 2.9 million Medicaid beneficiaries. Approximately 80 percent of our beneficiaries are enrolled in a managed care delivery system. Pennsylvania contracts with eight managed care organizations, and the remaining 450,000 beneficiaries are

enrolled in our fee-for-service program, and 350,000 of them are dual eligible.

During 2018, Pennsylvania Medicaid made several changes to the utilization management approach for opioid use disorder MAT, and the momentum for change really began in October of 2017 when the Pennsylvania Departments of Health, Human Services, Drug and Alcohol Programs, and Insurance held an opioid summit that brought together the Commonwealth's largest insurers, many of which offer products in both the commercial insurance market and the Medicaid managed care program. During the meeting, attendees collaborated on various options and strategies to combat the opioid crisis in Pennsylvania.

So, as a result of that summit, in February of 2018, a letter was issued to all insurers in Pennsylvania asking them to implement the recommendations from the opioid summit meeting. All payers in the Commonwealth were asked to implement, first, standard prior authorization guidelines and requirements for opioids; and second, removal of most prior authorization for MAT, with only specific and limited utilization management strategies remaining for MAT.

The Medicaid MCOs were required to implement the recommendations from the summit meeting.

The commercial payers in the Commonwealth also adopted the recommendations, and in October of 2018, Pennsylvania announced that all major insurers in the Commonwealth were removing prior authorization for MAT, as recommended by the summit.

So I'd like to take a moment to outline the specific MAT requirements. These were implemented by Medicaid fee-for-service in April of 2018 and by the MCOs in May of 2018.

First for buprenorphine, all Medicaid MCOs and fee-for-service are required to cover at least one buprenorphine/naloxone combination product without prior authorization. Due to health and safety concerns, the Medicaid MCOs and fee-for-service may require prior authorization for buprenorphine when it's not used in combination with naloxone; when it's used in combination with benzodiazepines and other CNS depressants; and three, in doses that exceed the daily dose limits.

The Medicaid MCOs and fee-for-service were only required to make one formulation of buprenorphine/naloxone

available without a prior authorization because there are several FDA-approved combination products. The pricing competition within this drug class allows fee-for-service and the Medicaid MCOs to garner manufacturer rebates for products designated as preferred or formulary by the payer. This strategy allows Pennsylvania to leverage value-based purchasing, while ensuring access to medication.

For naltrexone, all Medicaid MCOs and fee-for-service were required to remove prior authorization from Vivitrol or injectable naltrexone and also oral naltrexone.

Methadone for MAT, prior authorization was also prohibited for methadone for MAT.

And regarding naloxone, the opioid overdose rescue agent, at least one form of nasal naloxone must be covered without a prior authorization and without quantity limits. Naloxone is also copay-exempt for Medicaid beneficiaries, and naloxone is available throughout the Commonwealth via a standing order from Pennsylvania's Physician General, Rachel Levine.

In terms of MCO implementation, an operations memorandum was issued to all Medicaid MCOs outlining the requirements for MAT. Medicaid clinical pharmacy staff

reviewed and approved all MCO MAT policies for compliance with the operations memo. This is not a new process for Pennsylvania. Medicaid clinicians review and approve all MCO clinical prior authorization policies through a monthly prior authorization review panel process.

No prior authorization is required for outpatient drug and alcohol counseling, and as I mentioned, we have limited prior authorization requirements for the drug component of MAT, and documentation of participation and counseling is only verified for requests that exceed the quantity limit.

Prior to these changes, prior authorization was required for all buprenorphine prescriptions and for Vivitrol. The requirement for prior authorization was quality driven, and the fee-for-service Medicaid program used the prior authorization process to ensure that patients were evaluated appropriately and receiving the recommended level of care. We verified that patients were receiving counseling and other psychosocial supports and helped to link them with a provider, if needed, and we also assisted patients to find a prescriber that would not charge them cash for buprenorphine services.

We are fortunate to have a dedicated nurse case manager in the Pharmacy Division with expertise in drug and alcohol services who coordinates care and assists patients with many of these issues.

Since the prior authorization was removed, we have lost this touchpoint with some of our patients.

I think it's also important to note that despite the removal of prior authorization, there are remaining barriers to MAT. As we work with beneficiaries in Pennsylvania Medicaid, we continue to identify issues related to difficulty accessing buprenorphine prescribers. Cash clinics remain an issue, and we work with patients to try and help them identify providers who will accept Medicaid as payment in full for buprenorphine services.

We have also identified situations in which there are no openings with DATA-waivered physicians due to limits on the number of patients that they are able to treat.

It is unfortunate that it's easier for prescribers to write prescriptions for opioids than it is for prescribers to write prescriptions for buprenorphine MAT.

We also have seen patients struggle with wait

times between their initial drug and alcohol assessment and prescriber appointments. Just a few weeks ago, we encountered a patient facing a wait time of 30 days between their initial DNA assessment and being able to find an appointment with an opioid prescriber. Fortunately, our staff was able to intervene and link that patient with a prescriber.

Gaps in treatment are also occurring at times of coverage transitions, and lastly, emergency departments are not staffed regularly with buprenorphine prescribers and are not able to assist patients presenting for treatment.

So, in conclusion, while we still have miles to go in combating the opioid epidemic and addressing all the substance use disorder needs, the Pennsylvania Medicaid program has made great strides in improving immediate accessibility to outpatient MAT for OUD.

The number of beneficiaries with Medicaid paid prescriptions for buprenorphine and Vivitrol MAT increased 23 percent between 2017 and 2018.

The number of unique beneficiaries with Medicaid paid prescriptions for naloxone increased 163 percent from 2017 to 2018.

While we are seeing an increase in MAT utilization, it is difficult to know whether the increase is due to the lifting of the prior authorization or to other factors, including increased number of MAT prescribers, public awareness of OUD, or the epidemic itself.

Thank you.

* DR. SAN BARTOLOME: Hello. I'm Dr. Mario San Bartolome. Thank you so much for having me here. I represent Molina Healthcare, and I'm a practicing physician, still seeing patients that have substance use disorders, and I serve as the Medical Director for Substance Use Disorders. So I would say that I think Molina started off a strong and aggressive push towards addressing issues related to substance use in 2017, when they hired me, because I think that I came from the provider side, is probably a little risky, right, because we hear these complaints about prior auths, and those are things that I've experienced and experience. So those would certainly be on the list of things that I would want to address.

One of the most important things that we were

able to do at Molina was to really try to develop an entire system where we're trying to integrate behavioral health, which includes mental health and substance use disorders, along with physical medicine, because you really can't extract them, if you learn enough about opioids and you start talking about hepatitis C and endocarditis and a lot of other issues.

So we actually had to set out some values that we had when we were talking specifically about medication-assisted treatment. The first thing was that, really, medication-assisted treatment couldn't be just one little discussion about a medication, that it actually had to be something that was couched in a larger, more comprehensive type of approach that our whole organization -- and we're in 14 states and Puerto Rico, and so there are many different types of mandates from each particular state and also problems from the demographics that each state has in regard to how opioids affect people.

It also had to be agnostic as to whether somebody had an opioid use disorder, because, actually, just when somebody is prescribed opioids – and let's say they're on 3-, 4-, 500-milligram morphine equivalents, which is a high

number, that's a problem in and of itself. It doesn't necessarily mean that they have an opioid use disorder. And that is an early point at which we had to intervene. So we acknowledge that as well.

We also needed to know that we needed to accept -- and this was part of the training that started at Molina when I came in -- is that everyone needed to level-set -- the pharmacists, the case managers, the rest of the leadership -- that, you know, what addiction was, what Dr. Alvanzo has already described -- I think a lot of people don't understand addiction -- and how the medications are used. So actually we've created about 20 hours or so of training that the organization had to go through and still continues to go through so that we level-set when we have discussions about policy. It's actually quite a big deal.

But we also needed to say that medication-assisted treatment is an evidence-based, proven thing for opioid use disorder. And not everyone believes that still. Even though, really, it's clear in the industry.

We also needed to acknowledge that access to medication-assisted treatment was crucial and that that can actually thwart all other efforts if access was a problem.

And there needed to be alignment of the incentives and alignment of the policies across the whole enterprise.

The fourth thing is that, as a health plan, there really are some unique levers to pull. So depending on what angle you're coming from, whether you're an academic program or government group or a consumer group or, in this case, a health plan, the kind of tools at your disposal are different. And so one of the ones that health plans can use are information systems, and that's a very important one, how you can data mine. You have a captured data system. You can make decisions and measure things, and that's a very important thing.

And finally I'd say that Molina also had to come to the conclusion that it needed to collaborate and engage to be able to look for healthy communities. It couldn't be just, again, this isolated issue of MAT. There's a lot of press on opioids right now. However, SUDs, in general, it's a very big thing.

So let me cover some of the utilization management policies to highlight that we address. Number one, we removed prior authorization for buprenorphine and buprenorphine naloxone products, generic. So that was

obviously one of the first things on my list when I came in, for all the reasons that were already expressed. It's a delay-of-care issue and it can be quite dangerous. Maybe an extreme example could be if somebody comes in on a Friday, is pregnant, and has a heroin use issue, and you have to wait for a prior authorization, tell that person to continue shooting up over the weekend and maybe through the week until they get something approved. So that's gone away.

We also don't require things like somebody having to go through withdrawal management, or what people used to call detox, in lieu of being on medication-assisted treatment. And there are some groups that did do that. So you don't have to do that.

You also don't have to show failure of another drug, like naltrexone, which was another thing that was kind of implemented at one point, where people said you have to try antagonist therapy before you can go to agonist therapy, for various reasons.

You also -- we also asked that people do -- we do encourage that they have counseling as an adjunct to the medication, the pharmacologic therapy, but it is not a

requirement, and we also do count the actual encounter with the provider, because there is something that's very important to us in the field that we call motivational interviewing, or MI, that's quite effective. It's been shown to be very effective. And that's done when you're seeing the patient. It doesn't have to be a referral, and certainly there are lots of barriers in having to collect notes from people, and put them in packets to send for authorizations from the provider side. So we wanted to eliminate that and that's something that's not there.

There is a limit in terms of the dosing, but primarily for safety. So 24 milligrams being that dose, and it doesn't mean that you can't get more but if you do ask for more than 24 milligrams that then basically that does spark a prior authorization process. And, you know, most people don't exceed the 24 milligrams so it's generally not an issue. Most people are between 12 and 16 milligrams, actually. But you can overdo it.

There's also no duration limit at Molina for medication-assisted treatment. So we don't say you have to be on it for six months. We also don't say that you have to start tapering at some point. There's no like, "Hey, in

a year you're done with the bup, with the buprenorphine." That's not on the table. And again, that's part of the education process that you say, you know what? The idea of maintenance, there's no real limit to it, and that's something that kind of needed to be accepted across the industry.

There are no real barriers for the adjunctive counseling, so there's no prior authorization for that, for accessing the mental health for people with co-occurring disorders. Now I'll say that there are some variations between the states, because some states, for example -- I'll give you the biggest example -- would be a carve-out state, right, where it's carved out to the county, in which case with -- or the -- you know, the state.

So one of the things that we would have to do then -- this is kind of the position we've taken -- is even though Molina may not be the group that's actively managing the medication or that, you know, that treatment side, there are a lot of other social determinants of health around that and there are some opportunities for case management that better ensure that the person is engaged in treatment and stays in treatment for longer. And there's

not only a good argument for that from the medical side, there's a good financial argument for that. There's a good argument in all directions, that that be provided. So that's another thing that Molina is committed to.

In terms of pharmacy lock-ins and provider lock-ins, if you're in medication-assisted treatment at Molina you do not have to be in a pharmacy or a provider lock-in. Those do exist but they exist primarily for those situations that involve some sort of a fraud, waste, or abuse type of situation, where you see somebody going to more than three or four pharmacies in one month, getting narcotics, and there may be an issue with that, and they would be enrolled in that.

I'm going to transition now to talk about some highlights of the programs that we have. The main program that I started when I first came in was something called the Pain Safety Initiative, and I didn't call it the Addiction Initiative. I called it the Pain Safety Initiative because I wanted it to be inclusive, like I mentioned, not just people with substance use disorders but those people that are being treated for pain that carry a higher risk because they're also being given sedative

hypnotics, like benzodiazepines, along with opioids, possibly at high dose, maybe some dangerous opioids like methadone that can be used for pain, not just for opioid maintenance treatment.

And so we wanted to focus on a few things. Number one was to decrease the new starts. That means the people that transition from being acute to chronic opioid users. So after about 90 days of being on an opioid, the likelihood of you being on an opioid after about two years skyrockets. So we wanted to capture those people and those providers that maybe are not following guidelines early on, by starting people, let's say, on extended-release opioids right off the bat because you twisted your ankle. We wanted to be able to intervene in that. So along that line we started monitoring for high-dose opioids and risky regimens, like 90-milligram morphine equivalents, primarily for most states. The only state I think that's different is Ohio, because their state mandates 60-milligram morphine equivalents.

We started monitoring for co-prescribing for benzodiazepines and opioids. We removed Soma, which is a narcotic muscle relaxant from the formulary. We removed

methadone for pain indication from the formulary, because that's another one that's actually very much linked to people overdosing. We also addressed extended-release step therapy. So when people were started on opioids that they didn't start on something like, say, OxyContin right off the bat.

And one of the things that we started to immediately do as well is to start an educational campaign that included the providers. So the idea is to engage the providers. It's not something that providers are -- there's no punitive here. We need the doctors and we need as many X-waivered positions that can provide medications like buprenorphine.

So the idea was to create -- we created a resource section with CMEs that they can get on some of the common, difficult things that even in a primary care office, for example, tapering somebody off high-dose opioids, or dealing with somebody with a co-occurring disorder, somebody that's a perinatal situation where they're pregnant and using opioids. So they need to be armed with those resources. Not every provider necessarily knows that. And buprenorphine, or MAT in general, is not

just for addiction specialists. In fact, it's quite broad in terms of who does it -- OB/GYNs, emergency medicine doctors, primary care doctors. So we won't assume that anybody has the high-level training for the rest of addiction.

And so currently -- and I'll end here -- currently where we're focused now on the integration side. So all of those measures were more or less instituted. There's been some variation with some of the states that we've had to wait some time. But now what we're doing is creating a model of care for opioids, and this is where we've essentially taken the backbone of the care management team, and what we're doing now is looking into integrating the use of an opioid use navigator as a case manager. And that would be a person that has extra training in mental health, addiction, and pain management, and those things together would be kind of one expert among the care management team that can integrate some of the treatment.

So we also have other things, that I'm not going to go into too much detail here but I listed them for you here. But we had an SUD dashboard, and that dashboard allows us to look at heat maps, for example, of where

people are -- if they're overdosing, we want to be able to track some of those things. And there are metrics that are out there that are being used to compare apples to apples, like the Bree Collaborative, which has several metrics that have been chosen, that a lot of organizations are using, that look at the number of people on opioids, the number of people that have an opioid use disorder and are being prescribed opioids, the number of people with near-fatal overdoses. And that data together will help us make sure that we have network adequacy and be able to address the rest of the programs that we have.

So it's a multimodal approach, because it is a chronic illness. It is something that needs that kind of attention. It's not an episodic type of thing. And so I'll end there and entertain any questions for the Q&A.

CHAIR THOMPSON: Great. Thank you. I've asked Martha and Kisha to kick us off with questioning. So I think Kisha is going to go first.

COMMISSIONER DAVIS: Thank you. This was really helpful and highlighted a lot of the same things that I've experienced as a provider, treating patients with opioid use disorder. I think just highlighting, again, the

relationship between utilization management and prior authorization and the hardship that that can cause on the practice, who is trying to advocate for the patient, in terms of delays in treatment, the staff time, the provider time that's involved in that, and then also really just capturing the patient when they are ready to make a change. And especially with opioid disorder, when the patient is ready you want to jump on that, and waiting even a day or a week and saying, "Oh, well, you have to go to counseling first" or "You have to take this medicine that I know is less effective" and fail that, when they've already had a lot of failures, is really just delaying treatment and making the problem worse.

And so, you know, Dr. Alvanzo highlight a lot of that and I want to commend Dr. Hoover and Dr. San Bartolome for what they've done in their areas to really combat that.

I'm curious just thinking about some of the things that the Commission can do is really exploring this more, and what really is the evidence base for utilization management and prior authorization. How did we get to this place? Is it really helpful? You know, what's the return on investment in that? We talked a little bit about it

yesterday. But exploring that a little bit more and how is it really helpful or hurting, you know, in the broader opioid issue.

DR. ALVANZO: So I can say, just going back to the scenario that I talked about in Maryland, where we were -- we had previously had no prior authorization and access to all formulations of buprenorphine, and then the state decided to restrict to one formulation, and I can tell you it didn't come from the treatment community. It actually came from the criminal justice community, because of concerns for diversion of the film formulation of Suboxone in the criminal justice institution. Well, I think the solution to that is if we provide treatment in our criminal justice institutions then you have -- again, you decrease the risk of diversion if patients are getting treatment. So not all of these practices, or many of these practices are not evidence-based.

CHAIR THOMPSON: Any other panelists want to chime in and comment on this question?

DR. SAN BARTOLOME: Well, I'll say that in terms of prior authorizations, I think that its role would be more for safety issues than anything, at least in the case

of MAT. So whereas in some applications I think that people would try to divert one type of medication, but I think you mentioned, in the case of, say, doing -- using buprenorphine, for those that don't know how it's used, you have to go through a process called an induction, and it's something that, you know, can't wait and needs a lot of attention in the very beginning. It's timely. And there are a lot of other ways around that. Some organizations will allow for, say, seven days automatically, but then, you know, have some sort of a process to be able to track.

And so I think that in the past I think that there's been a little bit of heavy-handedness to somehow manage the provider to see if they're doing it right, which always kind of drives me crazy, because the providers have much more training than the people doing the utilization management reviews, in that particular thing. And that's where we find things like requiring the counseling, for example. That would drive me crazy because that's like going to the dentist and your dentist asking you if you flossed, and you said, "No, I didn't floss," and they say, "Well, you're not getting your toothbrush." Because you withhold buprenorphine because they didn't get counseling.

Well, that's ridiculous. And we do have, actually, decent information to show that even when people are just on buprenorphine, without any counseling at all, it still improves outcomes, in particular for injection use.

CHAIR THOMPSON: Martha.

DR. HOOVER: I would just add that in Pennsylvania, I think that when we had the robust prior authorization, the goal was never to deny. It was always about quality and safety. It was about making sure the patient was evaluated appropriately. We looked to make sure whether the prescriber was accepting Medicaid payment in full, so that the patient wasn't being charged cash.

So it was really about -- it was a quality-based initiative that was focused on setting that patient up for success. So that was the intent.

CHAIR THOMPSON: Martha.

COMMISSIONER CARTER: Thank you so much for your presentation. Your presentations all showed that you have an incredible depth of knowledge in this field, and I really appreciate that.

I wanted to support what Kisha said and highlight a few areas. The problems with prior auths translate to

problems for the patients and for the practices, and because real barriers to care, especially in some required counseling and prior auths for counseling services. We've had that be an issue where there's a prior auth to a particular counselor, the counselor becomes not available. Then there's a whole breakdown in the system. The patient can't get what they need, can't comply with the, in my state, the requirements for counseling. So I think, you know, that removing those barriers to care are really important.

Another place we've seen problems -- and I think one of you mentioned this -- is pharmacy lock-ins. Now I understand some of that, in terms of diversion, and we've had this happen. If the pharmacy doesn't have the drug, they -- I don't understand the pharmacy world very well but I think there have been situations where they didn't get all their order or they didn't have -- they didn't have the drug. They didn't have the buprenorphine. Then what's the patient supposed to do?

So I think we have to balance all these requirements with how is it going to affect the patient and the practice that has to track all this.

Sort of a little bit enlarging the field here, we've also experienced some lack of alignment with other areas of the system, especially the criminal justice system, the parole boards, the drug courts, the police, and I know that's beyond the scope of this Commission. But, you know, do you have any thoughts about how we can improve the general knowledge in the community, and with the other agencies that we have to work with?

I had a conversation with somebody from a parole board and was told that if a person who was on parole came in on buprenorphine that was considered breaking parole. So, you know, we've got a long way to go in basic public understanding, so I'm curious, you know, if there's any role for the Commission or for our programs in that. So that's one.

Another barrier still that this Commission has wrestled with is CFR 42 Part 2, especially in integrated programs. In the community health center, where I am, we hold ourselves to be an MAT program. We're subject to Part 2, and our providers, the PCPs and the dental staff and whoever, who get the patient records because they need to know, are considered legal holders of Part 2 information.

And so it creates a whole set of hoops that have to be gone through. And I, of course, understand the pros and cons of patient confidentiality but it's still a barrier.

One last thing. I may be jumping in Kathy's territory, and we talk about integration. We need to be talking about integration of oral health as well. We've seen a lot of the people who come in, in recovery, with very poor oral health. There's been a longstanding lack of care, and, of course, some drugs like meth are notorious for destroying oral health. And so most Medicaid programs don't pay for much oral health care. They might pay for the extractions but that's it. And so when we really are working on integrated care for people in recovery, we've got to look at those areas.

So I think I hit several things and comments on any of them would be -- I would be interested in.

DR. HOOVER: Just along the lines of the corrections, I can share that in Pennsylvania we have initiated a couple really interesting pilot programs where Medicaid is collaborating with the Department of Corrections, and that as folks are approaching release, they're set up perhaps with Vivitrol or some kind of MAT

treatments, and then Corrections notifies Medicaid, and then once we get that patient Medicaid-eligible, we are warm hand-off to a provider in the community, and we have case management in place to keep that going, recognizing that that period right after release is so vulnerable, especially for overdose. So we've really enjoyed kind of starting that process of collaborating with Corrections.

DR. ALVANZO: I mean, I think a lot of this relates back to stigma and the continued stigma regarding the disease of addiction, but also the stigma associated with the medications for treatment. And I think educating our colleagues in the criminal justice system about what we know about addiction as a chronic disease and what we know in terms of the literature about what are the most effective treatments with respect to mortality reduction and effects or association with criminal activity, it is medications. And so trying to educate them, but it's really about kind of breaking down that stigma that's associated, and we have a long way to go. There remains some stigma even in the addiction treatment community.

So we still have a long way to go, but I think that's one of the main things. And essentially what

they're doing is they are subsequently increasing somebody's risk for overdose or return to use if they're kicking them off their medication.

DR. SAN BARTOLOME: I would add that mandating training for the drug court judges probably wouldn't hurt, and that there is a bit of a slant to just the antagonist therapy in that world because of the stigma that was just mentioned. So I think that training goes a long way, and I mentioned that about, you know, in my organization, coming in and doing the training, it was 50 percent effort less just after having the conversation because everyone comes loaded with their idea of what addiction is.

In time, technology will help. We have a medication now called Sublocade, which is a long-acting subcutaneous version of buprenorphine, and that takes care of diversion.

And to the criminal justice system, that's an important thing, and I think it's a reasonable thing to be worried about. That will help, I think, over time. It's just very expensive. And I think over time that should go down, and whatever can be done in the pharmaceutical side to, you know, bring those prices down I think is another

area because they've been really high, about $1,200 to $1,500 a month, whether you're talking about Vivitrol or you're talking about Sublocade. And that's very difficult for many people.

CHAIR THOMPSON: All right. I have Kit, Fred, and Toby, and then Sheldon.

COMMISSIONER GORTON: So thank you for coming. We appreciate your traveling down. I want to as an observation particularly thank Kristin and Mario for doing really a lovely job in describing industry standard practices in terms of from a state program, the kinds of stakeholder engagement and other things you've done in order to get with your opiate summit or to get to what I think is a very fine outcome that you got for the Commonwealth, and certainly, Mario, the stuff that you've done is, I think, representative of what many high-quality health plans have tried to put in place to address issues like this. So thank you for coming and talking about that piece of it.

My question really goes to Mario. I noticed on your map that Molina does business in Texas and in Florida and in Puerto Rico. I'm particularly interested in Puerto

Rico. Do you have any observations about the impact of disasters, particularly the very disruptive hurricanes over the last couple of years, in those markets and particularly on patients who are requiring medication-assisted therapy? Have we lost access to that, particularly in Puerto Rico where there's been so much devastation of the infrastructure? Just anything you can share with us that -- the Commission has got active work going on in Puerto Rico, and it seems to me that this might be something that we haven't paid enough attention to.

DR. SAN BARTOLOME: Absolutely. Up until this last year, we were in charge of one portion of Puerto Rico, and now it expanded the coverage there. And they have an interesting system where the island itself has its own authority that covers, that manages the buprenorphine and access to all that. It's actually quite accessible. But you're right, during the hurricanes there were many people that were essentially just displaced and not able to access their medications. And so that was certainly a huge issue.

It's a difficult island to get information on. It's not the same system. They don't work on the same -- even our pharmacy system in terms of getting information.

And their physicians don't necessarily do things exactly like physicians on the mainland either in terms of how they go about, you know, using buprenorphine. But it is very much utilized there, and I think that we'll see probably more dynamics now that we've expanded the coverage area. And now that we've had the experience of the hurricanes, there's now a push to figure out contingency for that for the future. And I think the island is actually dialed in on that as well because that caused a disaster. There were many, many people not being able to receive their buprenorphine.

COMMISSIONER GORTON: And so in that circumstance, I presume some of them relapsed, returned to use. Have you seen any public health data in terms of near-fatal overdoses or fatal overdoses on the island?

DR. SAN BARTOLOME: I have not seen anything that shows a trend of a change. However, just anecdotally, if you don't have the -- I mean, it takes just a couple of days before the half-lives have dropped enough so that you're beginning to withdraw, and withdrawal in and of itself is kind of like a trauma. And so they would have probably looked for a way to be able to alleviate that.

So, unfortunately, that probably happened.

COMMISSIONER GORTON: Thank you.

CHAIR THOMPSON: Fred.

COMMISSIONER CERISE: Thanks. Great presentations and information. Thank you.

I have two questions, one very specific for Dr. Alvanzo. We've talked about 42 CFR Part 2 and the privacy thing. It's a little unrelated, but I'm curious, because I think you said you do a consult service, kind of an integrated system. I've been confused on how to interpret some of those things. Do you keep separate records?

DR. ALVANZO: So I actually -- I did direct the consult service at my institution up until June of last year. We did not keep separate records, although the interpretation of 42 CFR might suggest that you would. I'm an internist. I was integrated into the internal medicine service, so patients who are admitted to the Department of Medicine, their team identified that the patient had a problem, then we would go see the patient.

I think the interpretation would be that we would have had to have signed -- have each patient sign a release so that we could even talk to the providers who originated

the consult. So we did not do that. I know previously our organization had something called a qualified services organization agreement such that anybody within the institution could access the information. So that was how we approached it previously.

COMMISSIONER CERISE: I appreciate that. I think a lot of places are struggling with that same thing because it's just very impractical how you do the work that you would do in a separate form, with these integrated records and everything else that we deal with.

Second question, more for the group. You made a great case for why PA is problematic or you need to move. We just talked yesterday about a number of program integrity issues and how you sort of protect the programs. And, Kristin, you sort of touched on that a bit. What's the negative side of loosening up PA like this? And how do you protect the program? Recognizing that you've got to be looser on the front end, how do you get comfortable on the back end or, you know, overall?

DR. HOOVER: Well, I think the flip side of removing the prior auth is we don't know what we don't know. We're not seeing everything the way that we used to

see it, which was in real time, and it's tied to accessing that medication. So you had all the parties involved. So I think that how we're monitoring now is more like a data-driven approach because we have data available to us, so we're looking at more kind of analysis on the back end.

Certainly we still get phone calls from patients and providers concerned about different situations, and if those situations come to our attention, we absolutely intervene. But I would say we're not as in the weeds as we were prior.

DR. SAN BARTOLOME: I would echo the use of the information system. So, for example, you can have claims from a pharmacy that shows somebody on a buprenorphine product, and then loop back around if you wanted to add case management, to give them access to case management. Whereas, before, you would be able to do it right then and there, you can't. You have to wait, and there's delay in all things claims.

However, I think when you weigh it out, in the case of some of these medications, it's still more on the side of needing to be quick -- quick and have those options available right off the bat. And then you need to data

mine the rest, and I think with time that will get better.

CHAIR THOMPSON: Toby.

COMMISSIONER DOUGLAS: [off microphone].

CHAIR THOMPSON: Sheldon.

COMMISSIONER RETCHIN: I also want to thank all of you for participating. I thought your remarks were riveting and very reassuring.

I also want to thank our two Commissioners who kicked it off. It's always to me compelling to hear from our primary care Commissioners who are in the trenches and see this day to day.

As I listened to the discussion, I sort of come down on -- I know we're talking about utilization management, so those are issues of constraint. But the other area is really capacity, and I'm interested in your perspectives on: Do we have the capacity out there? The engagement of primary care physicians, is that occurring? And, in particular, I wonder if you have any reflections on rural settings?

DR. SAN BARTOLOME: So I think that that problem, the idea of adequacy of those providers that are X-waivered or even open to -- naltrexone you don't have to be waivered

for. However, I think there's an apprehension still because it's not normally in their tool case. I'm a family physician as well. I'm also boarded in addiction medicine. I can see both sides. Unless it's in that little tool case, you might not be familiar with it, and you might say, well, I'm going to send it off to, you know, somebody else that's a specialist. But particularly in rural communities, one of the things that we've done is we've made contracts with telemedicine MAT, groups that will provide the services, integrate into the community, and either in existing OTPs, opioid treatment programs, or with other services there and try to combine it with peer support, which are usually people that are in recovery, have had some advance training to get certified, because it adds another flavor of things. You know, the physician or the PA or NP is not always the right fit for the conversation. Sometimes you need a peer support person to be as part of that team.

And so for sure, using ways to break down the barriers of distance, incentives, maybe -- you know, up until recently, recently the group came out and gave free training for getting X-waivered, but before that, it cost.

So that could have been one incentive where you can train some people, incentivize. And another one would have been to Gold Card them, right? So if they show that they're providing care using proper guidelines, then you eliminate any need for any PA type things for their whole clinic, for their whole system. And you just kind of touch bases with them.

You can also have alternative payment models where you bundle things, because one of the things that makes it difficult to take care of somebody that's on MAT is that you -- it's not like taking care of a urinary tract infection. You know, in the world of fee-for-service, for an E&M code, a CPT code, that was like 99213, for example, that would be an average say like a urinary tract infection. I never had somebody come in that's on Suboxone coming to me and it take two minutes, three minutes. It's generally chaos, and I have to deal with it, and that's what they need. And I need to hire a peer support specialist. I need to spend more time looking up the reports for the PDMP. I need to contact the Mom, "What's going on? Why is he not here?" tracking them down. Well, I don't get paid for that. I have to have extra staff for

that. So alternative payment models, like P-Codes that ASAM and AMA have worked on, as an example. There should be other creative ones, too, that have to do with alternative payment models that allow for incentives and sharing in outcomes, like value-based type contracting. We're looking at those seriously, and that's a partial solution to that.

DR. HOOVER: I would say that in Pennsylvania access to prescribers is the biggest issue that we deal with. It's not diversion, abuse. Those kinds of calls rarely come in. It's really, "I can't find a prescriber," or "I have to wait a certain amount of time," or "This prescriber that I found wants to charge me cash."

So I think that in Pennsylvania we're making strides in getting more physicians X-waivered. We're initiating Centers of Excellence for the Medicaid program in both rural and urban areas, because certainly it's everywhere in Pennsylvania.

But I think stigma still comes back into play sometimes when we're talking with physicians and other providers about getting them engaged in the epidemic. That stigma still kind of bubbles to the top.

DR. ALVANZO: So I know today we are focusing on utilization management, but, again, there obviously is a workforce issue, and I think starting with our medical school training and integrating addiction treatment into our medical school training. There are some medical schools that are looking at revising their curriculum so that when their students leave, all of their students leave being X-waivered physicians. And so revising not only our undergraduate medical training but our graduate medical training, and then obviously offering CME for providers who are already in practice.

DR. SAN BARTOLOME: And the way to change that is to change the board questions. So if you want to know where to change it, you have to advocate for that, because that is what they teach to. That's number one.

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: I was going to ask about capacity, too, and kind of a combination of what do you do to recruit prescribers, but then also how do you work with prescribers to kind of stay aligned about training and new drugs coming to market and best practices around safety. And I'm just curious about kind of that dimension of

working with the network of providers.

DR. ALVANZO: I mean, I think there are a few different models. So recently, in Baltimore, our health department had extra money, had some grant monies, and they offered incentives for people to become -- a $1,000 incentive for people to become X-waivered. They're also working on a product where -- kind of based on the Vermont hub-and-spoke model where they have kind of similar to kind of Centers of Excellence, so you have opiate treatment programs that will kind of serve as the Center of Excellence or the hub, and then will work with different community-based practices and work with their providers to kind of educate them on how to do office-based buprenorphine. But if they run into problems and have patients who aren't doing well in that particular setting, then they can easily transition them to the higher level of care. They can come to the higher level of care, and then once they're stabilized go back to their primary care or office-based setting.

So I think those types of models -- also, in New Mexico, there's an ECHO model where the patient -- remote access provider education, so I think there are a number of

different types of models that could be employed to kind of increase the provider workforce, but then also help them as they're getting started in this area.

CHAIR THOMPSON: Alan, and then I'll jump in with some concluding questions.

COMMISSIONER WEIL: These were really terrific, informative presentations, and I agree it's also good to hear from our Commissioners who have experience in this.

It's fairly easy for me to see that if you're providing evidence-based care, sort of the blunt instruments of utilization management are at a minimum a hassle, and at worst, really an impediment to care.

I guess my question is -- we know from lots of places that a lot of people are getting care not in systems like the ones you describe, not necessarily evidence-based, entrenched in the biases and stigma that you describe in the under-training. So my question -- it's a little bit piggybacking on Fred's -- is: When you look out at the broader world of treatment, not just your own settings -- and this probably applies sort of to the policy change you made in Pennsylvania -- are there any utilization management tools, not just prior authorization, that are

valuable when they're sort of cast out to a fragmented, undereducated, somewhat stigma-laden world? Or is it really just -- well, I guess that's the question. Are any of these worth it to the portion of the delivery system that is not as organized and evidence-based as the ones that we've heard about today?

DR. HOOVER: I mean, I would say that utilization management, that's really focused on a safety perspective, like the excessive doses, and I think that you can put a positive spin on the utilization management too in terms if you're going to say we're going to remove copays.

So you can build utilization management rules that serve as an incentive or make it easier for the patients to access the treatments as well.

But I would say that quantity limits, there's still a place for those, and really when we look at a quantity limit request, we just want to see is this a thoughtful decision to increase the dose because we know that there's excellent providers, but there's also providers that aren't as well versed in this. So we're just looking to see that the appropriate workup is taking place, and we're not just inadvertently increasing a dose.

CHAIR THOMPSON: I'll follow that thread a little bit with some additional questions.

We just touched on PDMPs. So I would like to invite you to talk a little bit about the value of PDMPs and any issues that you see in checking those databases or efficiencies that you would like to see in that.

DR. ALVANZO: So I like the PDMP quite a bit. I find it to be a very valuable resource.

In Maryland, in July of 2018, the state mandated that for initiation of any new controlled substance, controlled dangerous substance, you had to check the PDMP prior to initiation of the first prescription and then ongoing every 90 days if you're continuing to prescribe.

I think there could be improvements in terms of the efficiencies in terms of our particular PDMP. Apparently, there's two different portals, and they're working on getting everybody the access to the newer version of the portal because sometimes when I go in and look up a patient, they may have five different profiles. And I have to click on each individual profile to see what prescriptions they may or may not have received.

We do have some coordination surrounding states

and the District of Columbia, but it's so easy to get on a plane or drive. So I think I like the idea of having the ability to see where they may have gotten a prescription, a controlled drug prescription, anywhere in the United States.

I do have concerns about PDMP being used for criminal justice purposes. I think it should be a clinical tool and not a criminal justice tool, but I have found it to be very helpful.

DR. HOOVER: So I actually brought some information on the Pennsylvania PDMP with me, and we have a PDMP. It's through our Department of Health, and it was implemented in August of 2016. I think what's unique to Pennsylvania is that we clinicians in the Medicaid program have access to the PDMP in addition to prescribers and dispensing pharmacists in the community.

Just to share some data from the PDMP, from third quarter 2016 to second quarter 2018, prescription opioid dispensing decreased by 23.5 percent. Benzodiazepine dispensing decreased 17.8 percent. Buprenorphine dispensing increased 14 percent, and the number of individuals prescribed greater than 90 MMEs of morphine a

day decreased 25.6 percent. So registration with the PDMP is required for all prescribers and dispensers licensed in the Commonwealth, and we have similar requirements as to how often physicians and pharmacists must access it when they're seeing patients.

It's been a very good tool in Pennsylvania, and I agree with keeping its use clinical.

DR. SAN BARTOLOME: I too am a big fan. It helps you make good decisions at the bedside, number one. If you have somebody that's coming in and you happen to catch, "Oh, this is a benzodiazepine prescription here. You didn't tell me about it. Let's talk about it," it's a wonderful thing.

And I would echo to say the fact that it's not integrated across the states is a problem, and that they're not the same. They're too heterogeneous. Everyone wants to have their own thing. So some of them have an ability to have workflow integration, use of delegates, or integration for the EMR, who can see it, who can't. There's too much heterogeneity. We wouldn't have that issue with ATMs, but we do for this. So I think that there needs to be some consolidation.

CHAIR THOMPSON: Good. I had some follow-ups, but, Martha, you're trying to get in on this?

COMMISSIONER CARTER: One thing about this, a new concern, people are addressing the opioid crisis and innovating rapidly, and I think it's difficult to sometimes keep up with all the changes.

One of the little things that came up for us is now our EHR pulls in the PDMP data, but because the state requires documentation that the provider check the PDMP, someone is having to actually -- I don't know how they're doing it -- take a screenshot or go into the other system and document.

So we need to be really on top of these things because even though that's an innovation that's helpful to the clinician, it's actually become a barrier. It hasn't improved. It hasn't improved the workflow because they still have to go through the old system to document that they checked the PDMP. So I guess that's to stay abreast of the innovations because they're happening fast.

CHAIR THOMPSON: I want to take the point about heterogeneous requirements.

I was really interested, Kristin. You were

talking about the fact that Pennsylvania really took a multipayer approach and got all of the payers in the state on the same page about how they were doing UM for these medications.

I wanted to invite you to talk a little bit more about what that required to get everybody at the table and then whether or not there's any comment, how much that helps providers in the education and in the engagement and the simplification to know that every payer in the state is going to see that service in the same way.

DR. HOOVER: Sure. So the initiative in Pennsylvania really came out of the Insurance Commission, and the Insurance Commission started some initial conservations with the Department of Human Services for Medicaid, Department of Health, and Department of Drug and Alcohol Programs.

Initially, the Insurance Commission invited the major insurers in the Commonwealth to participate in the summit meeting, and we were very clear in the invitation that they should include their physicians and pharmacy experts in the delegation that they sent to the summit meeting. We wanted to have a meaningful clinical

discussion.

So at that summit meeting, there was a lot of agreement in the room about what needed to happen. I think we are all facing the same problems, and many of the payers were looking for the state to tell them they needed to do this.

I think we see that sometimes when we're prior authorizing opioids that perhaps the prescriber knows that there's an issue, but when Medicaid gets involved and says, "We really need to do something. What are we accomplishing here? What's the goal with this patient and the chronic opioids that they're on?" it kind of forces that conversation.

So we came away from the summit meeting in a really positive, collaborative environment, and then we met over several months and developed the recommendations that came out of the summit. And in Pennsylvania, we can't require the commercial insurers to adopt those types of changes to their utilization management policies. It was an ask. So it was a letter, a joint letter from the secretaries of all those departments asking them to join the initiative and standardize how we're making MAT

accessible and how we're going to manage opioids going forward.

So I think from a provider perspective, it's been tremendous feedback regarding the opening up of the MAT. There's definitely appreciation for standardization. They know what we are going to be looking for and what is available.

I think that putting a prior auth on opioids, that's prior authorization work for a physician office. So there's definitely sometimes some give-and-take with that, but I think that for all the MCOs that have adopted these, we have all had great conservations about how you know this is really the right thing to do, that we really need to be focusing utilization management efforts on the opioids and that end of the epidemic versus the MAT and really making those services available.

DR. ALVANZO: I was just going to say in Maryland, I am the immediate past president of the Maryland-D.C. Society of Addiction Medicine, which is a chapter of the American Society of Addiction Medicine, ASAM. In Maryland, we actually had legislation passed because Medicaid did away with the prior authorization. We

actually had legislation passed that requires the commercial insurers to do away with prior authorizations as well.

CHAIR THOMPSON: And then I just want to circle back. I know we've talked a lot about prior authorization, but I just want to circle back on this point. And it's kind of a twofold question about this.

I think it's pretty easy to agree that prior authorization should always be evidence based. So it shouldn't be setting up requirements that have nothing to do with whatever it is you're actually providing and coverage policy associated with that.

How much of the issue with prior authorization, assuming it is evidence based, is about the fact that you can't get a response versus filling out the paperwork? In other words, if prior authorization weren't prior, if it was a file-and-use process, where I need to know certain information, and I want assurance that you're following these guidelines, and I'm not sure I can collect that information through other means, and I want to look at that early before months go by of dispensing this particular medication or not getting additional services that I think

could be helpful to this person, et cetera, but I'm not going to prevent you from going ahead and dispensing the drug, and I'm not going to prevent you from going ahead and proceeding with treatment, is that a kind of model that has been applied in different places versus we're taking down the entire PA program?

DR. HOOVER: Well, even when Pennsylvania had the prior auth, we had a five-day supply that they could get up front.

CHAIR THOMPSON: Okay.

DR. HOOVER: So they could start treatment and then work through the prior auth process, but I think that there's still that demand on the prescriber that has to submit all that documentation and all of the paperwork, which I think is significant feedback that we've heard from the provider.

CHAIR THOMPSON: So just completing the paperwork in and of itself, regardless of what it asks for or what it means in terms of payment or treatment, is the core of the problem, or at least a significant enough problem that --

DR. HOOVER: It's a part of, yes.

DR. ALVANZO: I'd say it's part of the problem.

CHAIR THOMPSON: Okay.

DR. ALVANZO: I wouldn't say it's the only problem, prior authorization, but it is a part of the problem.

I'm actually in an opiate treatment program, so I have much more time to spend with patients than people who are in primary care practice settings who have 15 or 12 or 10 minutes to see patients --

CHAIR THOMPSON: Yeah.

DR. ALVANZO: -- and trying to address all of these other issues, also manage their addiction, and now I have to fill out these. I'm sure there's other authorizations. It just adds an additional burden.

CHAIR THOMPSON: Okay. Thank you.

And is there a risk -- and this is my last question about this. Is there a risk of then moving those controls to the back end? So now I've taken down my PA program, but now I'm asking you for a lot more charts later?

Was that something, Kristin, in your conversations that was discussed about, all right, am I now going to do more pre-payment or post-payment review

associated with the claims and so forth?

DR. HOOVER: No. I think that our focus turned from a review based on the clinical documentation from the physician to more information system and data mining and looking at the data.

I'm eager to really dig into the data once we're a little further out from our implementation date. There's a lag with encounter claims.

CHAIR THOMPSON: Right.

DR. HOOVER: In a few more months, we're going to really be able to see what happens in our population. We're going to look at things like did we have a decrease in overdoses. What happened with the utilization? What does the retention in treatment look like? So we're really eager to dig into that, but I think it will be more of a data analysis versus --

CHAIR THOMPSON: Not a triggering of additional chart reviews and audits later. Okay.

DR. HOOVER: Yeah.

CHAIR THOMPSON: Okay.

DR. SAN BARTOLOME: And there are a lot of opportunities to look at that kind of data. An example

would be if you have a provider that is very high on those milligram morphine -- or lots of benzos attached to that, and I know with our system, we can also match the number of nonfatal overdoses attached to the patient which links to the provider.

So there are things to look at that are safety issues, and you can go further. You can talk about other sedative hypnotics, also by age where there's a lot of elderly on polypharmacy that have several sedating medications, even like tricyclic antidepressants. There's a lot of ways that you can do that with data systems, using a code.

CHAIR THOMPSON: Right. You can do that various analysis all day, all night, right, on that?

DR. HOOVER: Yeah.

CHAIR THOMPSON: And then your suggestion is that that would -- again, using clinical indicators -- give you a much better use of resources, a much better focus on the issues that are going to actually matter than a kind of 100 percent, one-size-fits-all prior authorization, regardless of practice, et cetera.

DR. HOOVER: Yeah. And we build those kind of

rules in our system as well for our Medicaid clinicians. We want to see patients who meet these three parameters, and then we'll take a closer look at those patients. And if needed, we will reach out to those prescribers and have a conversation. But it's done through data on the back end.

CHAIR THOMPSON: Good.

DR. SAN BARTOLOME: And you have to have the programs attached to that, that address it in the right way.

On our end, we wanted it not to be punitive. We didn't see that as being the way to go about things. There will be those people that are three or four standard deviations away. They'll sort themselves out, and that might be a network issue, but most of the time, when we start communicating with them and let them know, "By the way, we have adopted the CDC guidelines on prescribing opioids for chronic pain. We also have adopted ASAM guidelines for opioid, --medication-assisted treatment."

"These are the things that we have resources online already for you to learn about how to do that. There are webinars." We can , --outreach, set a plan, and

then that's I think the proper way to go about it locally.

CHAIR THOMPSON: Thank you.

And, Nevena, I'll just mention I think that we need to take that into view when we talk about utilization management, so it's not always the up-front mechanisms, because I think that's helpful to understanding the totality of what are the approaches available.

Thank you. This has, I think, been -- we've kept you a little bit past our time. That is also our practice.

[Laughter.]

CHAIR THOMPSON: But we really, very much appreciate the insight and the expertise that you've shared with us this morning. It's been extremely useful.

If we could just ask you to hold on one second while we invite the public to make any comments.

PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: Seeing none, we will take a break. We will be back at, let's say, 20 of for some further discussion.

* [Recess.]

CHAIR THOMPSON: Okay. We'll reconvene here. So

we have about 20 minutes for the Commissioners to discuss if we -- whatever points or conclusions we want to be sure to mention to Nevena as we consider what we heard this morning.

EXECUTIVE DIRECTOR SCHWARTZ: She has a few things she wants to say.

CHAIR THOMPSON: But before we do that, I think it would be good, Nevena, if you could also just give us a reminder about what it is that we're supposed to be producing, so we can keep that in mind as we talk about this subject, knowing the wide range of interests of the Commissioners. And, you know, anything else that you want to share with us about how you're thinking about this or what you've done thus far.

FURTHER DISCUSSION OF UTILIZATION MANAGEMENT OF MEDICATION-ASSISTED TREATMENT

* MS. MINOR: Sure, yeah, and I think I definitely want to hear your -- take this time for you to reflect just more generally about any kind of future or ongoing work of the Commission, but then also in the context of the congressionally mandated study, I just want to outline what the components are of that, but, of course, there's always

other things beyond that, looking to the future, that we could do beyond the study.

So the study was part of the opioid legislation from last fall and it had three components to it. First, it asks us to identify quantity limits and refill limits that are placed on MAT medications, and for this portion we're actually using findings of a study that was just recently released by SAMHSA. It was commissioned by the Substance Abuse and Mental Health Services Administration and looked at Medicaid coverage and utilization management policies for MAT drugs, at a 50-state level, kind of looking at top-line, whether it required certain policies. So we're relying on that for the quantity limits and refill limits piece.

Second, the bill asked us for an inventory of utilization control policies for ensuring access to medically necessary MAT. And so we're supplementing the findings of the SAMHSA study with additional analysis illustrating policies in eight states, and for that we're reviewing publicly available documents for both the fee-for-service program and when applicable for the MCO, or in the case of a carve-out, the BHO, with the largest

enrollment, to identify any relevant policies. And those kinds of policies include, frequency limits to counseling visits, the specifics of requirements related to prior authorizations, step therapy requirements, or, requirements to get psychosocial treatment.

And thirdly, the study asks us to determine whether MCO policies and procedures are consistent with federal regulations related to what has to be in a state Medicaid contract. And so for that we'll just describe the contract language in the selected eight states and highlight any instances where the contract language goes into additional detail beyond what's already -- what's required by the federal regulation.

And the deadline for the study is October of this year, so that's outside of our regular report cycle, so we'll just plan to issue a standalone report. And it's also worth noting that the provision in the bill didn't ask the Commission to make any recommendations, and we anticipate presenting a draft of findings from our policy review later this spring.

CHAIR THOMPSON: Martha.

COMMISSIONER CARTER: Well, I apologize kind of,

but maybe not, for conflating the conversation earlier.

I would like us to make some recommendations around these -- at least the things that we're reporting on, and I'd be happy to work with you all on that. But I think we've heard pretty clearly that there are barriers to care, there are barriers to access, and there are barriers to workforce because of some of the prior auths and lock-ins and various things surrounding these programs. So I would like to see us work towards recommendations.

CHAIR THOMPSON: One thing to think about, I guess, with some of these -- and I liked, kind of, the texture of the conversation that we had, both with the panelists and as we were asking questions -- about with something like prior authorization, trying to really decompose that into why are people asking certain kinds of questions, and how -- are there other ways in which people can be thinking about developing that information and creating those kinds of controls to provide the level of confidence that they're looking for?

And so, you know, having a broader view than -- I mean, prior authorization does have its place, as does lock-in. I think the question of how do you apply that,

how do you target it, how do you make sure that you're obviously connecting to the clinical evidence but also utilizing other kinds of tools that can be available, that can be potentially less burdensome on the providers.

I was really glad to see some good feedback on PDMPs, and I think that deserves calling out as well, some of those additional opportunities for further enhancement and improvement and use of PDMPs, alongside of some of these other approaches and tools.

I did want to mention, Toby, as he was -- had to leave a little early and he did want to at least note, you know, in terms of thinking about something like prior authorization, not necessarily in this space but potentially in others, that we need to be careful that we are, you know, thinking carefully about how to take down barriers to access while we're also ensuring that we do have the proper control in place, so that we're not sort of swinging the pendulum back and forth, which, you know, sometimes we do. You know, we'll take them down but then now we have new problems and we'll put stuff back up. So how do we go about this in a very sensible, data-driven, evidence-based way to ensure that we're making the right --

setting the right balance?

Kisha.

COMMISSIONER DAVIS: And to that point about prior authorization and how we look at it, and recognizing that the safety and efficacy and wanting to make sure that providers are prescribing in the right way and that patients are being taken care of in doing -- you know, that everybody is doing the right thing. And, you know, prior authorization, in the past a lot of times has been used as a hammer or hatchet across the board to everybody, and I think we got good information that what we really need is a scalpel. And we have big data and we have better ways now to identify who the bad actors are, that we didn't have before.

And so, you know, and reports and recommendations, recognizing that there are better ways to identify where problems might be, looking more specifically at quantity limits, you know, and dosing and numbers of prescriptions and things like that, as opposed to using tools that go across the board to everybody.

CHAIR THOMPSON: And even distinguishing between bad actors and providers in need of education, right? And

there's also a distinction between how you handle some of those issues.

Kit.

COMMISSIONER GORTON: So very quickly, I would align myself with what Penny and Toby said. Prior authorization has its problems, particularly if it's done in a heavy-handed way, but it's an important tool. And I would be reluctant for the Commission ever to be perceived as being somehow opposed to prior authorization. I mean, fundamentally, prior authorization is a level of control and, fundamentally, human beings doing like being controlled. So there's always going to be that tension there. That doesn't mean we shouldn't do it right and do some of these other things.

I think the emergence of PDMPs -- and you heard Kristin Hoover say the PDMP has been in a functional state, in the Commonwealth of Pennsylvania, since 2016. That's a pretty recent development. And so I think as these other tools come along, as the data systems can support some of these other things, nobody wants to -- prior authorization is no fun. It's not a great program to operate. But for the time being, sometimes if all you have is a hammer, then

you have to use a hammer to get it done.

I wanted to call out something else that Kristin said, to make sure that we attend to it, Nevena, when we talk about the development of evidence-based guidelines, and Penny's point about multipayer participation. But even if we're just talking about competing Medicaid MCOs in a particular marketplace, the plans worry, and appropriately, about selection, and nobody wants to be the first plan to -- I mean, the problem with Sovaldi was not that there weren't plans who wanted to drop the fibrosis scores. The problem with Sovaldi is that the plans wanted to be sure that everybody dropped their fibrosis scores at the same time, because otherwise, particularly given the freedom of changing that often exists in Medicaid managed care programs, where, in many states, people can change their managed care plan as many times as they want, as often as they want. To get labeled as the plan that's easy-going about a particular thing is an invitation to the prescriber community to push people into that plan, and that adverse selection can be enormously problem, again, Sovaldi being the most important case in point.

So I think that this idea that Kristin Hoover

talked about, about creating cover, whether it's for the insurers, so that they get a level playing field, or, candidly, whether it's for the prescriber community. I mean, I used to remember the tension. "I want my kid on Ceclor for his ear infection," right. There's no worse antibiotic than Ceclor for ear infections, but they want Ceclor, and if you didn't write it then the guy three offices down the hall would write it. And so, you know, what is the point?

So I think to the extent that the Commission can be calling up the need for evidence-based treatment guidelines, which is something that the country has been somewhat resistant to in the past. You know, we struggle with this. The AHRQ actually got themselves defunded in the '90s for going down that path. So evidence-based treatment guidelines are not something that has necessarily broad acceptance, and so on the one hand you say, well, you know, you can only do something if you have an evidence base, and on the other hand there may not be an evidence base, or they may not be an authoritative organization that's willing to develop that.

So I just think we need to keep in mind that in a

market-based system like we have, sometimes the playing field needs to be level, and sometimes there are educational needs. But sometimes, also, there are just -- there needs to come to a commonality of point of view about what the evidence says and what it doesn't say, and that can be time-consuming and sometimes expensive. I happen to think that it as, I think, Pennsylvania showed with their opiate summate, time well spent, and the return on that is well worth the energy that goes into it.

CHAIR THOMPSON: I also think the two sides of that -- so to the extent, for example, prior authorization was trying to collect certain data or encourage certain behavior or require certain things, and to the extent that without that we think there is some way to kind of accumulate that knowledge in a different way on the back end, just like we think about what's the evidence and the clinical basis for whatever we're dealing, from a coverage policy standpoint up front, if we had some way of talking about what we think are the key indicators of success and performance on the back end, or the kinds of things that would indicate, oh, we have emerging concern.

So again, in terms of thinking about an ecosystem

where you're trying to get people access and you're trying to educate providers and you're trying to get multiple payers on board, also how are we looking at how we're doing on the back end and how are we attending to the question of are we doing well at a top line but we've got a certain set of pockets that we need to be concerned about, and what does that look like and how do we know that those pockets exist?

We have Chuck, Melanie, Darin, and Sheldon.

COMMISSIONER MILLIGAN: Grant panel, Nevena. Well done. I think it was the best one I've seen in a long time.

To me, the point I want to make is I think, you know, we've had a lot of conversations about the continuum, and we've previously talked a lot about IMD issues. I think the more we can elaborate on, in the report, the -- that there is sound outpatient approaches and what kind of the factors are around sound outpatient approaches, because there continues to be, and even recently, with SUD, a lot of policy activity around IMD. And I want to make sure that we continue to work on contextualizing treatment across a continuum.

We heard that on the panel, I think it was in the fall, around IMD, that, you know, it's an important part of the continuum but we shouldn't focus on inpatient to the exclusion of the whole continuum. And so I think the more that we can draw out from this discussion the factors that predict a good approach to outpatient treatment and access and safety and all of that, I want to continue to contextualize this topic within a continuum of care.

COMMISSIONER BELLA: My comment is related to Chuck's, and it's just if you -- you know, looking at what they ask us to study about individual access, it just goes back to the core -- if they don't have MAT coverage to begin with, like just focusing on PA and other things kind of misses the point. So I know we did a chapter about that last year, and the SAMHSA report, it looks like, also mentioned that we're going to draw from, also looks at coverage. In terms of the broader context I just think it's important to keep sort of beating that drum and not just focusing on the limits that assume that coverage is already in place.

CHAIR THOMPSON: Darin.

COMMISSIONER GORDON: First, to your point, I

think that's, you know, getting to the back end, or ways to make it an easier process. I mean, and part of that gets to if you have multiple plans for the market, taking different approaches. Obviously that doesn't help. You know, that only complicates things.

But I think where one of the panelists were talking about, you know, the value-based purchasing, going in that route, where you're looking at outcomes and measure on outcomes, I think that gets a little to your point. So it sounds like there's some thinking being done there but I haven't heard a lot of that progressing, but I think that needs to be a component of what you look at around getting to your issue.

But with regards to PDMPs, you know, I'm with you. I think there are a lot of states that are just fairly new into it, and I think the one thing that would be helpful if we touch on PDMPs is not just looking at whether or not one exists. I think one of the issues -- and, I mean, we see it, and I think it was highlighted in regard to Pennsylvania -- that in some cases the Medicaid agency folks don't have access to it. So I think that's really important thing to make use of those -- effective use of

the PDMPs. So just going at least one step beyond just saying does one exist, I think that would be helpful.

CHAIR THOMPSON: Sheldon.

COMMISSIONER RETCHIN: I know we want to stay in the lane here. I'm going to sort of drift away a bit. There was mention on the question on rural health about telehealth. We, as a Commission, have reported on issues of telehealth, but particularly going back to the March report, we said that there may be issues related to access through the MCOs versus fee-for-service. And to that end there was a theme issue at Health Affairs on telehealth in December that also highlighted some of the barriers in this. And I just wonder -- maybe, Nevena, do you have any reflections on the comment that was made, especially for rural access?

MS. MINOR: So, I mean, I think some states are looking at telehealth as a way to expand access, and I think federally there are, I think, different grant programs and initiatives happening to support that. I mean, beyond that I can't really speak much to it.

COMMISSIONER RETCHIN: One thing that -- I don't know whether it was in our report or it was in one of the

articles in Health Affairs, they mentioned that one of the barriers was being able to prescribe over telehealth, telemedicine.

MS. MINOR: Yeah, there's some trickiness around, with the originating site and distant sites with -- you know, you have the waiver prescriber and then who can be where the patient is. And I think there's some -- I think some of this might be restriction and some of it might be some areas where there needs to be more guidance, and I know that DEA has said that they were going to issue some additional guidance or regulations on it but we haven't seen anything yet. But I really can't speak to it in great detail, but that is -- there is -- I mean, well, probably more than a hiccup, but there are some issues there.

CHAIR THOMPSON: Okay. I agree with Chuck. That was a great panel. That was very useful, right on target for what we're required to respond to. And I do think that the discussion that we had with those panelists and the discussion that we've just had helps even broaden the conversation to important points that I think we're all interested in seeing addressed.

So thank you for your work on this, Nevena, and

we'll look forward to hearing more from you on this subject in March or April?

EXECUTIVE DIRECTOR SCHWARTZ: April.

CHAIR THOMPSON: April. Okay, good.

All right. So we will go ahead and turn immediately -- because we have not had enough Rob in this meeting.

[Laughter.]

CHAIR THOMPSON: And we have not had enough DSH in this meeting, to talk more about DSH, and talk specifically about defining Medicaid shortfall.

ACCOUNTING FOR THIRD-PARTY PAYMENTS IN THE DISPROPORTIONATE SHARE HOSPITAL DEFINITION OF MEDICAID SHORTFALL

* MR. NELB: Great. Thanks, Penny. Just when you thought you were done with DSH, I'm back again, this time talking about ways of accounting for third-party payments in the DSH definition of Medicaid shortfall.

So I'll begin with some brief background about Medicaid patients with third-party coverage and the history of the DSH definition of Medicaid shortfall, and then I'll review some of the state and provider effects of a recent

court ruling that has changed this definition, and some potential policy approaches that the Commission may want to consider.

If you'll recall, you all flagged this at our December meeting, and because this issue doesn't affect state DSH allotments that we talked about yesterday, we're sort of dealing with it on a separate track today.

So just as background, as you know, an individual can be eligible for Medicaid even if they have other forms of health insurance, and in many cases Medicaid provides important wrap-around services for these individuals. So, for example, many elderly and disabled Medicaid enrollees are also enrolled in Medicare, and they use Medicaid to help pay for Medicare premiums and cost sharing.

In addition, many individuals who are in need of long-term services and supports often seek Medicaid coverage to access these services, even if they have private coverage that covers their acute medical needs.

Medicaid is generally the payer of last resort, particularly for hospital care, so with Medicare, for example, Medicare is the primary payer for hospital services for dually eligible patients. And for many

patients with private coverage, that coverage includes coverage of hospital services.

In order to coordinate benefits, providers typically have to bill the third party first, and then they bill Medicaid for any remaining costs. However, in the case of patients with private insurance, hospitals typically receive payments that exceed what Medicaid would have paid, so they often don't end up submitting a bill to -- or don't end up getting paid by Medicaid for those patients.

In 2017, approximately 18.4 million Medicaid enrollees reported third-party coverage, according to the American Community Survey. As expected, Medicare was the most common type of third-party coverage for the disabled and elderly enrollees, and private coverage was the most common type of coverage for non-disabled adults and children.

So as you know, DSH payments to an individual hospital cannot exceed the hospital-specific limit, which is defined as the sum of a hospital's uncompensated care for both Medicaid and uninsured patients. Uncompensated care for Medicaid patients, which is referred to as

Medicaid shortfall, is defined as the difference between a hospital's costs of serving Medicaid patients and the payments that the hospital receives for those services. However, this definition gets a bit complicated for Medicaid patients with third-party coverage because the hospital receives payments from both Medicaid and the third-party payer for these patients.

The specific definition of Medicaid shortfall has changed a bit over the years, and so I just want to walk through some of the history.

So the hospital-specific limit was first added in 1993, but it received renewed attention in the 2000s when states were required to audit hospital uncompensated care costs. In 2008, CMS finalized a rule describing DSH audit requirements, which described how uncompensated care costs should be reported, including how Medicaid shortfall should be calculated.

Prior to the 2008 rule, states used a variety of methods to account for third-party payments, and even after the rule was finalized, there was confusion about how these payments should be accounted for. As a result, in 2010 CMS issued subregulatory guidance clarifying its position that

third-party payments should be subtracted from the shortfall calculation.

CMS began applying this policy in 2011 when it began enforcing the DSH audit rule, and in doing so, it found that some hospitals were receiving DSH payments in excess of the hospital-specific limit as defined by CMS. When CMS began to recoup funds from these providers, several hospitals challenged CMS' 2010 policy in court, arguing that the subregulatory guidance that CMS issued represented a change in policy that required formal rulemaking.

In response to these legal challenges, CMS issued new regulations specifically about third-party payments that were finalized in 2017 and codified CMS' 2010 policy. Hospitals continue to challenge this rule, arguing that the policy is inconsistent with the language of the Medicaid Act since the statute does not explicitly mention third-party payments. In March of 2018, the D.C. Federal District Court sided with the hospitals on this issue, concluding that third-party payments cannot be subtracted from the shortfall calculation. CMS has appealed this decision, but in the interim, it has withdrawn its 2010

guidance and has stated that it's not enforcing the 2017 rule at this time.

So jumping ahead now to the effects of the court ruling. This change, as I said, does not affect the total amount of state DSH allotments, but it will substantially increase the amount of Medicaid shortfall that individual hospitals report since third-party payments will no longer be subtracted. And this largely has an effect about how DSH payments get distributed within a state.

Patients who are dually eligible for Medicare and Medicaid will account for most of this increase since they're frequent users of hospital services and since Medicare is the primary payer for this care. Other types of hospitals impacted include children's hospitals because they often serve a large number of children with disabilities that have both Medicaid and private coverage.

So this figure illustrates the effect of the court ruling on Medicaid shortfall for a scenario that might be typical for many dually eligible patients enrolled in both Medicare and Medicaid. In this hypothetical example, we're assuming that total hospital costs for this particular patient are $100 -- just hypothetical.

[Laughter.]

MR. NELB: It would be $100,000. But, anyway, $100, and that Medicaid and the third-party payments collectively cover 90 percent of these costs. And we're assuming that most of the costs are paid by the third-party payer since Medicaid is a payer of last resort.

So as you can see, under CMS' 2010 policy, if you subtract both Medicaid payments and third-party payments from calculating Medicaid shortfall, the amount of shortfall reported in this scenario would be $10. However, under the definition under this new court ruling, third-party payments would not be subtracted, and in this case, the total amount of Medicaid shortfall would be much higher.

The substantial increase in DSH-eligible uncompensated care costs as a result of this court ruling has the potential to affect states and providers in two different ways.

First, some of the states with unspent DSH funding may spend more of their DSH allotment. This is particularly true for a handful of states that have historically had DSH allotments that are larger than the

total amount of uncompensated care in their states, and as a result, historically they haven't been able to spend their full allotment.

New Hampshire is an example of one of these states, and because hospitals in New Hampshire were among the first to file lawsuits against CMS' prior policy, we actually have some early evidence about how the new change is affecting payments in that state. So in 2014, for example, DSH payments increased 50 percent in New Hampshire once they started applying this new definition.

Second, the court ruling may change the distribution of DSH payments in some states. In 2016, about half of states distributed DSH payments based on the amount of hospital uncompensated care as defined on their DSH audits. In these states, DSH funding will shift from hospitals -- will shift to hospitals that serve more Medicaid patients with third-party coverage if the state policies don't change.

We're already seeing some of the early effects of this policy in some states, such as Texas, which is also one where providers in the state were among the first to file lawsuits. In Texas, some of the early data suggests

that the changes resulted in more payments to children's hospitals and smaller payments to large public hospitals.

It's important to note that states are not required to use the new DSH audit definition of uncompensated care when they are targeting payments within their states, and so states could avoid some of these effects by changing their DSH targeting policies, either by using a different definition of uncompensated care for distributing payments or by coming up with another policy that they would use to distribute DSH payments within their states.

In previous meetings, our Commissioners expressed concern about the potential effects of this court ruling since not subtracting third-party payments will allow hospitals to effectively receive duplicate payments for care that is already compensated. However, as you consider approaches to address this issue, I also want to highlight some other considerations that might be relevant for particular types of third-party coverage situations.

So, first, for dual-eligible patients, it's important to recognize that, of course, Medicare is another public program, but also that Medicare also makes a

different type of DSH payment to hospitals that serve a high share of low-income patients, and Medicare DSH payments also have a similar goal of trying to offset some of the costs for those patients.

Second, for Medicaid patients who are privately insured, it's important to recognize that payments from private insurers often exceed hospital costs, so under CMS' 2010 policy, any surplus that hospitals received from privately insured patients who are also Medicaid-eligible, that surplus would be offset against any shortfall that those hospitals reported for Medicaid-only patients.

Moreover, as I mentioned earlier, because hospitals often receive full payment from private insurers, they often don't actually end up receiving any payment from Medicaid for those patients, so it's a little harder to track the payments and costs for those patients in the Medicaid claims system.

If the Commission does want to recommend potential alternatives to the court ruling, your memo outlines a couple potential approaches to consider.

First, the Commission could recommend including payments from third-party payers in the calculation,

similar to CMS' 2010 policy.

Second, the Commission could recommend excluding payments and costs for patients with third-party coverage from the definition entirely so that these patients do not affect the DSH payments that hospitals receive for Medicaid-only patients.

Third, the Commission could consider developing different rules for different types of third-party coverage situations, such as individuals with private coverage or Medicare.

That concludes my presentation for today. If you are interested in making recommendations on this issue, we can further develop policies of interest for consideration at the March or April public meeting in order to include the recommendation in the June report. Thanks.

CHAIR THOMPSON: Thank you. Melanie.

COMMISSIONER BELLA: Yeah, I would just like to express support for making recommendations.

[Laughter.]

CHAIR THOMPSON: I am in agreement about trying to pursue this. I have a variety of questions, though. I want to be clear about so states can basically solve the

problem apart from federal law or regulation -- they can make a decision for themselves about how to handle these situations.

MR. NELB: Yes, they -- it requires a state plan amendment to change their policy, and it probably is going to be a more prospective rather than a retrospective. But, yes, they -- and states are sort of figuring out what to do about this, but that is a possibility. Nothing -- this ruling, basically because it only increases the amount of Medicaid shortfall for a hospital, there's nothing saying that a hospital -- they can't just get paid based on the prior definition.

CHAIR THOMPSON: Okay. And what is the argument -- I think we were stuck last time we sort of touched on this issue. What is the argument for not including third-party payments? Like there's got to be a rationale. I'm setting aside for the moment the idea that like CMS -- did CMS go through the right process to make a policy change or whatever. How do hospitals -- what is the hospital's logic for why those that, you know, prefer to have the policy look like it does, what is their argument for it?

MR. NELB: So I would say the strongest arguments

I've heard are in certain cases for patients with private insurance, such as low birth weight babies, who are automatically deemed eligible for SSI and are automatically eligible for Medicaid even if they have private coverage. So that's a case where the very expensive patient and the hospital -- they have very high costs, and the hospital, though, already -- if they're already privately covered, they're receiving payments for that. So if the hospital receives a surplus for that patient, that surplus gets sort of -- once you add that into the DSH calculation, it reduces the amount of DSH payments that the hospital could receive for the uncompensated care that it actually has for uninsured patients and for Medicaid-only patients.

So I think the --

CHAIR THOMPSON: Well, but that's just a more money argument.

MR. NELB: Yes. Yes, I mean, it --

CHAIR THOMPSON: Okay.

MR. NELB: And then, yeah, there's a stronger case -- in the case of Medicare, it's harder to maybe make the case, but in this case, it's the privately insured patients where the hospital isn't billing Medicaid for the

service, and I guess the hospitals don't see that patient as a Medicaid patient even though they are being enrolled in Medicaid maybe to access some additional services outside of the hospital. So those are the patients that are typically --

CHAIR THOMPSON: Getting coverage from the private insurer. We're not stopping them from getting coverage from a private insurer.

MR. NELB: Yes.

CHAIR THOMPSON: Okay. All right. Who else wants to jump in here? Let's see. We have Kit, Fred, and Leanna.

COMMISSIONER GORTON: So I just want to -- one, I agree with Melanie and Penny that we should make a recommendation here. I'm not sure what it should be, but I think we should say something.

I want to follow up, Penny, on your question because I think I don't understand the answer, if I heard it right. The states can fix the internal distribution problem. But the states can't fix the uncompensated care ceiling problem, right? So if we move outside New Hampshire, let's talk Pennsylvania, which has historically

not spent the DSH allotment because they have low levels of uncompensated care. That ceiling has just moved up substantially, and Pennsylvania, at least as I can think back about it, has often had the resources and the motivation to draw down every piece of federal match that it can, and so that's something that nothing other than revising the statute can fix, right? Is that right?

MR. NELB: Right. I mean, of course, Pennsylvania could choose not to make the DSH payment, but it is unlikely that they would do so given that they have the resources and given the example we saw in New Hampshire and others where their current policy is basically to spend the maximum allowable DSH that they can.

CHAIR THOMPSON: Okay. I'm glad that you asked for that clarification, Kit. Fred and Leanna -- and then Sheldon. I'm sorry.

COMMISSIONER CERISE: Well, I hesitate to weigh in, but I also feel like I have to. Full disclosure, we are intimately involved in these discussions in Texas with significant impacts on the public hospitals, and my hospital is one of those. And so I'll put that out as full disclosure, but also kind of as a way to say, you know, I

see how this plays out at the state, and essentially, you know, you've got hospitals that have won this ruling that says they can get paid twice by an insurer and then get this counted as a Medicaid shortfall, and then they bring that ticket to the state and say they'll apply the formulas that you have in place today. And it's resulting in significant shifts of hundreds of millions of dollars in funds in aggregate, tens of millions of dollars on the individual hospital level, essentially shifting public dollars to pay again for care that was compensated by some other source.

And so states can do this with state plan amendments. That takes time. Things get confused at the state level, as you know, and so it's not a simple -- it's not a simple clean and neat thing. This seems like a pretty clear-cut thing that we could make a recommendation on.

So just to let you know sort of how it practically plays out, and it's resulting in some pretty dramatic shifts.

CHAIR THOMPSON: Thank you for that.

Leanna, Sheldon, Brian.

COMMISSIONER GEORGE: I just want to comment that both of my kids are also privately insured through my husband's work, and as a parent, I'm leaning toward the idea of making a recommendation to not include the third party in the shortfall definitions, but -- to include. I'm sorry.

But my question is regarding with high deductible rates. How is that playing into the whole numbers game that we're talking about? Because I know we have like a $2,000-per-person, then like a $10,000-per-family deductible before we get any real assistance with hospital-related care. So that might be something to consider.

CHAIR THOMPSON: And that's connected to the point that Chuck raised yesterday about that subject, in general, around third-party liability and coordination of benefits, and I think that's worth paying attention to.

Rob, is there anything that you'd like to say on that subject?

MR. NELB: I can take a closer look at how it works. Generally, Medicaid shortfall, it's the difference between the cost and then the payments that the hospital received. So that I guess it could potentially include

some cost sharing that's paid by the patient as well as the private coverage and whatever is left by Medicaid, but I'll take a closer look at that issue for sure.

CHAIR THOMPSON: Sheldon and Brian and Chuck.

COMMISSIONER RETCHIN: Well, I'm with everybody else. It doesn't seem right to be paid twice, and it seems obvious to support that.

The only point I would make, I guess, is that -- it's been tied up in courts, but I think CMS has had seven decisions against it. They issues a final rule, and it still hasn't -- somebody said they're on a pretty long losing streak here, but I think it's fine for the Commission to support a recommendation in some way regarding it. But I think it's going to be settled in court.

But I am sensitive to Leanna's point about the high deductible and the bad debt. Then nobody wins on that.

CHAIR THOMPSON: Although, Sheldon, I would just clarify that we would make a recommendation on the statute, and so you can lose on process grounds and on the current language of the statute.

COMMISSIONER RETCHIN: I'm all in favor.

CHAIR THOMPSON: Right?

COMMISSIONER RETCHIN: Yeah, sure.

CHAIR THOMPSON: Okay. Brian and then Chuck.

COMMISSIONER BURWELL: So I have a question. In terms of the policy options that you outlined at the back, I mean, I would assume that our recommendation would primarily be going towards the first option. I don't really understand the second option and how that differs from the first option and how the impacts were different.

MR. NELB: Sure. So the difference between the first and second option, the first one would go back to CMS's 2010 policy, which under the 2010 policy, the cost of patients with third-party coverage is included in the shortfall definition.

For example, with Medicare dually eligible patients, Medicaid DSH is paying for Medicare shortfall, right, so paying for any remaining costs that Medicare doesn't pay for those dually eligible patients.

Then one of the other corollary effects of it also is this case I highlighted with the Children's Hospitals, where if you received a surplus for a privately

insured patient, that subtracts against any uncompensated care you had for other patients.

So the difference between the first and second option is that the second option would just exclude those patients with third-party coverage entirely. So Medicaid DSH would no longer be paying for Medicare shortfall, and those circumstances that the Children's Hospitals have raised around some of those high-cost patients with private coverage, it would no longer be a factor in the Medicaid DSH calculation. So that's some of the difference between those two.

CHAIR THOMPSON: So I think our expectation would be with an interest in formulating recommendations that we would have a discussion to draw out some of these different approaches, and that would be the basis for then a decision about the recommendation that we would want to make.

I think we need to tag you, Rob, with the responsibility to kind of come back. If the situation as it exists is not one that we think is the right situation, what's the exact change that we're calling for on the statute, and what are the pros and cons of that? I think there will be an opportunity to kind of figure out.

MR. NELB: Okay.

CHAIR THOMPSON: There's one here that's a stronger fix than another.

Chuck.

COMMISSIONER MILLIGAN: I'm supportive of doing something too.

I had a few questions, actually, Rob. Do we know how Medicare DSH handles this issue?

MR. NELB: Sure. So Medicare DSH does not -- even though kind of in theory, it helps support the costs, the higher costs that a hospital may have serving a lot of Medicaid and SSI patients, Medicare DSH payments are not actually based on actual uncompensated -- or not based on Medicare shortfall or anything. So that's not part of it.

There is a piece as part of the ACA, Medicare DSH divided into two pots. One pot is paying for uncompensated care as defined on Medicare cost reports, but that's more for the uninsured. And then the remaining portion that is distributed the way Medicare DSH has historically been paid, which is based on hospital’s Medicaid and SSI days.

COMMISSIONER MILLIGAN: The second question is the effect of this -- I mean, to pick up on what Fred said,

it's redistributive I think in general from safety net hospitals to less safety net hospitals.

Maybe this is more, sort of a follow-up to bring back, unless you want to have a comment now. Are there ways of getting at this issue from the deemed kind of framework, the qualifying hospital framework, without tackling it frontally? That interplay between the definition of "deemed" and "eligible" hospitals, it seems to me is kind of related to this, and I would like to better understand how.

The third comment I want to make is back to the high-deductible plan and Leanna's comment. Let's say there's a family $10,000 deductible, and they have trouble meeting the deductible, and therefore, they have trouble getting access to the private coverage because they have trouble meeting it. Understanding that interplay with uncompensated care, the difference between bad debt and uncompensated care can get mushy sometimes. I think there's a problem here we need to address about hospitals getting paid twice.

What I want to make sure we don't do is assume they're getting paid once when they're not, because a

patient has private insurance coverage, but they have difficulty accessing it because they have difficulty paying their deductible when they are low income enough to qualify for Medicaid.

So I just want to make sure that we are thoughtful about that piece of it, which I'd also like to better understand.

Any comments you have about any of that, I'm happy now or when we come back to the topic.

MR. NELB: Sure. I'll follow it more for sure.

But in terms of the deemed DSH, I just want to distinguish there are different rules for sort of which hospitals are eligible to receive DSH payments, and then the rules for how much DSH payments a hospital could receive. So this change affects that latter question, the hospital-specific limit, how much a hospital could receive, and it doesn't change whether a hospital is deemed or required to receive DSH payments or not. We can certainly look at the extent to which deemed DSH hospitals are more or less affected by this change.

Then on the latter question, we'll definitely get back to you on the deductible piece. There is a part where

if an individual has private coverage, but that coverage does not cover the service, they are considered uninsured for the service, and so they actually are included as uncompensated care but on the uninsured side of it. I'll give some more information to kind of work through that scenario.

COMMISSIONER MILLIGAN: Maybe it gets at it from a cost report side or some other reporting side, but I just want -- again, I reiterate my comment, but I want to make sure that the private insurance actually is received by the hospital without assuming it is.

CHAIR THOMPSON: Okay. Any last comments on this subject, before we open it up for public comment, from the Commissioners?

Let me just ask for public comment on this before we conclude our conversation on this topic.

PUBLIC COMMENT

* MS. OSSMAN: Thank you very much.

I am Aimee Ossman. I'm from the Children's Hospital Association, and as you might imagine, we have some different thoughts on this topic.

We did send a letter to the Commission on January

9th, just to share our perspective, but I don't want to go into all of that here in the public comment.

But I did want to just note that, as you all know, this is a very complex issue and plays out in different ways in different hospitals, and I don't kind of feel that the Children's Hospital perspective, getting into that detail, is really reflected here. If it would be helpful to walk through what's happening at the Children's Hospital level or other hospitals that are impacted, we'd be happy to set that up.

I think this isn't black and white issue, and the DSH funds have been redistributed once after the 2010 change in policy, and now there may possibly be another redistribution. So I think kind of thinking of it in that longer term framework would also be helpful.

Obviously, you all know Children's Hospitals are major Medicaid providers. Medicaid DSH is very important to them and for their ability to provide care to all children and be that critical provider. So we're very interested in working with you on this issue.

We appreciate your thoughtfulness as you're looking at this, and we do appreciate you delaying your

recommendation until you can kind of delve into it further and look at the different impact because it is really a redistribution, two different hospitals at the state level.

Thank you very much for the opportunity to comment.

CHAIR THOMPSON: Thank you, and we will, I'm sure, be back with you to try to make sure that we're taking all relevant facts into consideration as we finalize any direction here.

MS. OSSMAN: Thank you.

CHAIR THOMPSON: Any other public comments?

[No response.]

CHAIR THOMPSON: Okay, Rob. So I think we've given you some feedback about what we're interested in, and I think it would be very helpful to come back with some more granularity and detail about impacts, effects, and potential pros and cons of different approaches we've discussed here. So we'll look forward to that at your earliest next opportunity.

Okay. Any final comments from Commissioners before we adjourn or from the public?

[No response.]

CHAIR THOMPSON: Okay. We are adjourned. Thank you.

* [Whereupon, at 11:37 a.m., the meeting was adjourned.]