PUBLIC MEETING

Reserve Officers Association
Top of the Hill Banquet and Conference Center
One Constitution Avenue NE
Washington, D.C. 20002

Thursday, March 7, 2019
9:35 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

[9:35 a.m.]

CHAIR THOMPSON: We will open up. Welcome, everyone, to the March meeting.

Our first session this morning is going to be on prescription drug policy and a couple of potential ideas for improving operations in Medicaid. So we'll ask Chris to kick us off.

PRESCRIPTION DRUG POLICY: POTENTIAL RECOMMENDATIONS ON COVERAGE GRACE PERIOD AND REBATE CAP

* MR. PARK: Great. Thank you.

Over the past couple years, the Commission has heard about the challenges states face in covering new drugs, particularly those that are high-cost specialty drugs.

At the last September meeting, staff presented policy options for providing states with a grace period, during which they would not have to cover a new drug or formulation. Staff also presented an option to remove the cap on Medicaid rebates.

Many Commissioners expressed interest in both of

these recommendations and asked staff to come back with more information, including CBO scores on these policies.

For the grace period, I'll provide background information on the federal requirements for coverage for Medicaid and other federal payers, Medicare part D and qualified health plans.

We also provide rationale for either a 90-day or 180-day grace period, including information from an informal survey of states on the process and timing involved in reviewing drugs.

For the rebate cap, I'll provide background information on the cap, estimates of savings for removing the cap, and then rationale and considerations for removing the cap.

Should the Commission decide to move forward with either of these recommendations, we ask that the Commissioners come to a decision on the potential options provided for each recommendation, specifically should the grace period be for 90 days or 180 days, should the grace period be paired with a requirement that states have a formal coverage policy in place at the end of the grace period, and should the rebate be completely removed or

raised to 125 percent of average manufacturer price or some other percentage.

Under the Medicaid drug rebate program, states must generally cover all outpatient drugs from the manufacturer with a rebate agreement, and states are required to cover a participating manufacturer's drug as soon as it's approved by the FDA and enters the market. If a state has a preferred drug list, then the state is required to use a Pharmacy and Therapeutic, or P&T committee, to determine placement on the preferred drug list and other coverage guidelines and restrictions, such as prior authorization.

The P&T Committee is responsible for making coverage recommendations based on a review of the scientific literature and other sources of information, such as prescribing guidelines from professional societies. This review process can be time- and resource-intensive.

To get a better understanding of how states develop their clinical coverage criteria for new drugs, we sent a set of focus questions to state Medicaid pharmacy directors and conducted informal interviews with four states and received written responses back from five

states.

Based on the information we collected, we found that it could take anywhere from a week to six months for a state to evaluate a new drug and develop coverage criteria. Some states said that it takes a matter of weeks, but most states said it usually takes around two to three months.

Additionally, a few states said it's much faster to review a new drug or a new formulation of a drug in an existing class than it is for a novel drug, a first-in-class treatment, or a new drug class.

While a few states have monthly P&T meetings, most state P&T meetings meet quarterly.

In addition, P&T meetings are typically open to the public for comment and testimony, and states may have public notice requirements that require the agenda to be set a few weeks in advance.

In addition, some states allow for public comment for a period of time after the committee meeting, such as 30 days before they can implement any of the committee's recommendations.

If a drug is introduced too closely to the next scheduled P&T meeting, many states would have to wait more

than 90 days until the next scheduled meeting to review the drug.

One state mentioned that for new drug classes, it can take two meetings, and those are meetings that were held quarterly, to finalize any recommendations.

While a drug is being reviewed, the drug generally is placed on prior authorization. The level of prior authorization may vary, and many states do prior authorization on a case-by-case basis. In these situations, it may not be clear to the beneficiary and a prescribing physician that the drug may still be available on a case-by-case basis and, thus, the state is effectively not covering the drug.

Both qualified health plans sold on the exchanges and Medicare Part D plans are allowed a grace period to place new drugs on their formularies following FDA approval. For QHPs, they are required to make a reasonable effort to review new drugs within 90 days of approval and make a coverage determination within 180 days.

Medicare has a similar requirement, except for the six protected classes, which require a coverage decision in 90 days. If there is no coverage decision after

90 days, then the new drug is placed on the formulary.

As discussed previously in September, the Commission may want to make a recommendation that Congress provide Medicaid a similar grace period. This would require amending the statute, Section 1927(d)(1)(B) of the Social Security Act, to allow states to exclude or otherwise restrict coverage during the grace period.

The grace period provides states time to develop coverage criteria to help ensure medications are prescribed appropriately for medically accepted indications. This would also codify a practice that is already taking place informally in many states, while providing clear guidance to states, beneficiaries, and manufacturers on what is permissible.

In September, Commissioners thought the Medicaid grace period should align with the federal standards for QHPs and Medicare Part D. The Commission could recommend a 90-day grace period, which is the standard for Medicare's six protected classes. Because Medicare plans must cover all or substantially all FDA-approved products within these classes, it is somewhat analogous to Medicaid's coverage requirements.

From our survey, we found that most states could do a clinical review within 90 days; however, many states may have to change their P&T schedules and review processes in order to implement a coverage decision in 90 days.

180-day grace period would align with the standards for QHPs and the non-protected classes of Medicare Part D. This longer grace period will allow states to maintain their P&T processes and timelines but may create longer access delays for beneficiaries.

Another option that we discussed in September would be to pair the grace period with a requirement similar to that used in Medicare Part D, which requires plans to put new drugs that are part of a protected class on the formularies after the evaluation period is over.

The Commission could recommend that there is a requirement that the state publish and implement coverage criteria at the end of the grace period. If coverage criteria has not been established and published by that time, then the state must cover the drug as a preferred drug; that is, no prior authorization until formal coverage criteria are in place.

This requirement would incentivize states to use

the grace period to make informed coverage decisions and not simply delay access to the drug. This requirement could be done through regulatory guidance implementing the grace period.

CBO provided estimates of the fiscal impact of instituting either a 90-day or a 180-day grace period, and both were estimated to save less than $25 million over 10 years. The savings are primarily a result from shifting spending into a later period. The 180-day grace period would produce slightly more savings, but that's hidden by these ranges.

States have said the grace period would be helpful in providing them time to develop coverage criteria. Many states said that 90 days would be sufficient, but 100 days would provide the most flexibility.

They may have some objections to the coverage requirement after the grace period, particularly in some states where they have laws in place that may make it difficult to meet that timeline under certain circumstances, particularly if the grace period were for 90 days.

Enrollees may face delays in access; however, they may already be experiencing some delays already. The coverage requirement at the end of the grace period would provide enrollees a clear timeline on when they should expect access to the drug.

Drug manufacturers would likely oppose a grace period, as they would argue that once they are required to pay the rebates, states should be required to coverage the drug, and that the mandatory rebates of the Medicaid program render the program different than Medicare or QHPs.

Manufacturers may be more accepting if there is a coverage requirement after the grace period that provides clearer timelines on when formal policies should be in place.

We will move on to the potential recommendation on the rebate cap.

Under the statute, drug rebates are capped at 100 percent of a drug's average manufacturer price. Based on data we got from CMS from the fourth quarter of 2015, about 18.5 percent of drugs reached the rebate cap. This is a significant number of drugs are reaching the rebate cap.

The policy generally applies to drugs that have

significant inflationary rebates due to large price increases over time. Some policymakers have argued that the Medicaid inflationary rebate benefits other payers by discouraging steep price hikes. Once a drug hits the cap, however, the manufacturer can raise prices without being subject to corresponding increases to its net rebate obligations to Medicaid.

In other words, manufacturers would essentially be giving Medicaid the drug for free because the rebate is equal to 100 percent of the drug's average manufacturer price, but it could increase the drug's price even more to obtain greater revenues from payers without any additional losses on the Medicaid side.

The Commission discussed either removing the cap entirely or raising the cap to somewhere over 100 percent, such as 125 percent of average manufacturer price. This would require a statutory change to Section 1927(c)(2)(D).

Removing or raising the cap would increase Medicaid rebates and can ensure that the Medicaid inflationary rebate continues to exert downward pressure on price increases.

One thing to note is that this policy would not

necessarily address all high-cost drugs. Exceeding the cap generally depends on the manufacturer triggering a high inflationary rebate. Just having a high price does not mean that the manufacturer would exceed the cap, and removing the cap would not address the issue of high launch prices.

CBO estimated that removing the cap would generate about 15- to $20 billion in savings, federal spending, over 10 years, and raising the cap to 125 percent would generate about half that amount, so 5- to $10 billion over 10 years.

States would see a decrease in spending as well, as they would share in the increased rebates.

It is unlikely to have a measurable effect on enrollees, and manufacturers would have to pay the higher rebates. They are opposed to this policy and have indicated that it could lead to higher launch prices or cost shifting to other payers.

If the Commission decides to move forward with any of these recommendations, you will need to make a decision on a few of the options presented. Specifically, should the grace period be for 90 days or 180 days? Should

the grace period be paired with a requirement that states have a formal coverage policy in place at the end of the grace period? And should the rebate cap be completely removed or raised to 125 percent of average manufacturer price?

Once you have made a decision on these options, staff will come back with a draft chapter and recommendations for a vote at the April meeting, and the chapter and recommendations will be included in the June report.

Here is some draft language for you to consider as you discuss these options.

With that, I will turn it over to you.

CHAIR THOMPSON: Okay, great. Thanks, Chris.

Let's go ahead and keep those up as we have a conversation.

Let me just start off with a couple of questions just to refresh our memories here, starting with the grace period. When are we saying that the grace period starts? Is it with the signed rebate agreement or with the approval of the drug by FDA or some other place?

MR. PARK: We could do either. Generally, most

manufacturers already have a signed rebate agreement in place. The first time point would be when it enters the market after approval by the FDA. It is usually the smaller manufacturers who -- you know, maybe this is their first drug on the market --

CHAIR THOMPSON: Right.

MR. PARK: -- that don't have a signed rebate agreement in place.

You can make a determination on which date you would want their grace period to start from, but when the drug enters the market, there would be information out there for the states to start making a coverage decision before the manufacturer actually had a signed rebate agreement in place.

CHAIR THOMPSON: Okay. Just to clarify, when we say the drug enters the market, what does that mean?

MR. PARK: Sure. So the FDA may approve the drug, but it's not available for purchase until a certain date. So when we say a drug enters the market, it basically means when it is first available for purchase.

CHAIR THOMPSON: First available for purchase by anyone?

MR. PARK: Yes.

CHAIR THOMPSON: I remember that we had a discussion about this and certainly thought that states should go through a process here. We could understand why they needed a process and why they needed time for the process.

But remind me why that process couldn't begin in advance of a drug entering the market. So, in other words, if you believe that you need 90 days or 120 days or 180 days to make a decision, is the information absent that would tell you what you needed to know prior to the drug entering the market, or is there uncertainty about when and where and how the drug will enter the market that prevents states from acting earlier to initiate this process?

MR. PARK: So I would have to do a little bit more research, but states can do some evidence gathering because they know certain drugs are in the pipeline or are expected to be reaching the market soon.

I don't think that all of the labeling indications are available until it is officially approved.

CHAIR THOMPSON: Okay. That's helpful. Thank you.

Then I just had one question on the rebate stuff to clarify this, and then I am going to go to Kit and then Darin.

On the cap on rebates, I understand why it could have an impact on prescription drug pricing, and I understand why it can provide cost savings. But it doesn't affect anything having to do -- it's using the Medicaid rebate program, but it's not that anything changes for Medicaid as a result of raising the cap; is that correct?

MR. PARK: Well, I guess it depends on what you mean by does it have any effect on Medicaid. There could be certain pricing decisions made because if we raise or remove the cap, that would affect Medicaid.

CHAIR THOMPSON: So say more about that. What it feels like is that it's a point of leverage, but we're using the rebate program. But the Medicaid is not incurring additional cost or reduced cost are a result of that. There is a savings coming through the Medicaid rebate program associated with it.

MR. PARK: Medicaid would receive higher rebates because instead of it being cut off at 100 percent of average manufacturer price, it could go beyond that.

CHAIR THOMPSON: Right. But in excess of what they actually paid out.

MR. PARK: Yes. The manufacturers in these situations could potentially be paying Medicaid to utilize the drug because it's over 100 percent of average manufacturer price, which is generally what they -- you know, their, like, list price.

CHAIR THOMPSON: Correct. Okay.

All right. Let me go ahead and turn it over to Kit and then Darin.

COMMISSIONER GORTON: So thank, Chris, for once again taking an incredibly complicated, arcane topic and sensitizing it down into a reasonably understandable form.

I would be supportive of moving forward with a recommendation on the grace period.

With respect to 90 days versus 180 days -- and here, I will simply express my experience in 30 years of doing this. Yeah, you can get it done faster if you have to, but you cut corners and you don't do things that you would otherwise and under the best of circumstances do. So I would argue for the 180 days.

Also, I know you know this, Chris, but in your

comments, just for the general public, if you have managed care plans who are relying on guidance from the states, they have their own P&T committees and their own processes and their own notice requirements and those things, and you cannot compress a state process and a managed care process into 90 days and not do violence to the process.

So I would argue just on the basis of practicality that it's going to take people that long, anyway. We might as well give it to them.

I think that levels the playing field. You diplomatically pointed out that some of the states had not been adhering to the requirements straight on. Other good states are out there doing what they're supposed to do, and so it would seem like if we could create a manageable expectation, then CMS would have more opportunity to go to the states that have been sort of overlooking this particular requirement and put more pressure on them to actually comply. From a fundamental fairness point of view, that makes sense to me to do it in that way.

The one other thing I would say about the grace period -- and this gets a little bit to Penny's point about is there information now available -- FDA often approves

things and even requires post-market surveillance, which is often not forthcoming in as timely a fashion as one would like.

So what I would like to do -- and this is probably not for the recommendation or for statutory language, but in the commentary, to point out that for states to be able to work through this process, the manufacturers then have to do their part and produce the post-market surveillance in a timely fashion to help states get to where they need to go.

The last thing I would say on the grace period is I don't think we should mandate a formal coverage policy at the end of it for the reason that you suggested. Some state laws -- states just have different ways of doing things, and so I just think that creates an administrative burden without necessarily creating much by way of benefit. So that's what I would do with that.

In terms of the rebate cap, I would support a recommendation raising the rebate cap, and I guess I didn't see any reason -- the 125 percent seems to me to be just a number, and so absent some rationale around that number, I guess my bias would be let's just get rid of the cap.

If there's a reason to have the cap raised to a particular number, then I would just want to understand why it was that we picked that number in the grand scheme of things.

CHAIR THOMPSON: All right. I have Darin, then Peter, then Stacey. I'll add Sheldon and Fred.

Chuck.

COMMISSIONER GORDON: Chris, thank you for your work.

On the coverage topic of the grace period, from personal experience, I'm supportive of us doing something there. I agree with a lot of with Kit said. Whether it's 90 or 180 days, I can make an argument for either.

Kit hit on a point, and this is responding to Penny's question. What we often ran into is we were basically trying to create coverage criteria in the dark because even the information from which FDA ultimately approved a particular agent wasn't made available to a state in a timely fashion for us to react.

So that's not helpful, and I think that's why I do think having a grace period, using the process, so that it is an informed coverage criteria is helpful for all

involved. So I greatly appreciate that.

I don't know what the average time delay -- I didn't even think about it. Kit was talking about some of the prospective surveillance requirements, and I wasn't even thinking about that. I am supportive of doing something here on that issue.

On the rebate side of things, oftentimes it would seem to me -- it's like yes. You raise that. That's helpful to states. That could generate savings to states and the federal government; however, typically when it comes to pharmacy pricing, in particular, you touched one thing, and it impacts multiple other areas.

I would suspect it would likely have some impact on what states see in regards to supplemental rebates because I could see where there could be less supplemental rebates offered in that scenario, in that situation.

I don't know if that's true, Chris, or if you thought about -- I mean, I would assume there's a potential for it, as you were saying. There's also the potential for changing it in pricing as well. I think there could be some impacts that we can all anticipate.

I do think that 125 percent is a number, Kit.

You are exactly right. It is a number. I would actually be more inclined to use just the number than taking off, as we would end up learning more I think in the process, what happened, how did the system react, than just taking it off. I think that's taking too big of a step.

CHAIR THOMPSON: Peter.

COMMISSIONER SZILAGYI: Yeah. Thank you, Chris.

This topic always fries my brain, and I really appreciate your helping us.

About the rebate caps, two naïve questions. One was related Was the issue of the 125 percent that we actually might learn something, like this is a staged process, and then in the future, it would go higher? Or do you think there are so many other complexities that it would be impossible to disentangle the effect of this from what we would learn?

My other question had to do with enrollees. There is kind of an assumption that this wouldn't affect enrollees. Could you talk a little bit about the possible scenarios by which it might affect enrollees?

So one extreme example would be if they leave the Medicaid market. I can't imagine that actually would

happen, but what might be possible scenarios in which this could affect enrollees?

MR. PARK: Sure. There wasn't like a strong rationale as to why we chose like 125 percent to raise it, but I think the Commissioners had discussed not removing it completely but just like raising it to a certain amount. So it could be used, as you and Darin have suggested, as maybe like a study period to see what the effect would be for that.

CHAIR THOMPSON: If I can, I think part of the conversation was what are we trying to accomplish with eliminating the cap. It wasn't just let's collect a bunch of money from drug manufacturers. I don't think that's a policy rationale. I would make an argument, right?

So it was actually to influence behavior, and then the question was how far do you need to go to influence the behavior that we are trying to achieve.

COMMISSIONER SZILAGYI: And that is what I was -- because 125 percent may not be large enough to be able to actually evaluate that there might be a change is what I was suggesting.

MR. PARK: Yeah. And in terms of what that might

do on beneficiary access, as you mentioned, potentially a manufacturer could either stop providing that drug to Medicaid or there could be other implications of them like leaving the market. If it was like a particularly important drug like insulin, then maybe that could create some shortages for beneficiaries.

The Medicaid rebate program is tied in like participation with other federal programs. It's just like 340B and things like that. So there are further implications of leaving the Medicaid rebate program than just Medicaid.

CHAIR THOMPSON: Stacey.

VICE CHAIR LAMPKIN: Thanks.

Thanks, Chris.

I have two questions. The first one relates to the grace period and I think specifically the coverage requirement that might be paired with that. I understand the potential implications to beneficiary access. Are there any beneficiary safety considerations that we should -- observations that we could make to either -- especially that required coverage? Is the P&T committee in their consideration -- is that UM prior auth criteria that have

safety implications above and beyond the FDA approval indications, or is it about cost? Is there anything we need to say? That's the first question.

MR. PARK: Sure. The P&T committee usually tries to consider things like safety, efficacy, like comparative effectiveness first before they look at cost. So, generally, cost only comes into the equation when they're weighing drugs that they have evaluated as being similar in terms of effectiveness and safety.

So the P&T committee can put into place as part of like the prior authorization requirements, things on follow-up for certain testing like viral loads that they've done with some of the antiviral drugs like hepatitis C. They want to check like after a few weeks that it does appear to be reducing the viral load, and they may also require certain testing requirements or lab tests with certain drugs. So there can be like a safety aspect as well to the requirements that the P&T committees put in place.

In terms of -- okay. Was there another part of your question? I can't remember.

VICE CHAIR LAMPKIN: Wells, so I'm hearing that,

and so I think that required coverage as a preferred drug after 90 days, if no decision has been made, then potentially has safety implications, or no? Because the state P&T committee hasn't weighed in and --

MR. PARK: Well, I mean, it might be similar to what is the current environment right now in that if the state hasn't appropriately evaluated a drug and beneficiaries request the drug and receive it --

VICE CHAIR LAMPKIN: But it would be prior authed now --

MR. PARK: It would be prior auth now.

VICE CHAIR LAMPKIN: -- and wouldn't be under if I understood correctly this requirement to treat it as a preferred --

MR. PARK: It doesn't have to be prior auth, but most states would have an automatic prior auth in place for any drug they haven't reviewed.

VICE CHAIR LAMPKIN: Yeah. Okay. So thank you. I think I understand.

My second question is related to the rebate cap, and I think it kind of goes along the lines of why are we doing this because I agree with the kind of push the

balloon in one place. It moves somewhere else kind of dynamic.

The point of doing it might bring money to Medicaid, but the idea, the reason for doing it is leverage around inflationary pricing of drugs in general. Is that a correct understanding?

MR. PARK: That's a lot of the rationale.

Also, if policymakers wanted to change the rebates within Medicaid -- maybe they want a further penalty on inflationary pricing or something like that -- then raising the rebate cap would allow those policies to have their full effect.

VICE CHAIR LAMPKIN: Yeah. It's just very strange to think we could be saying remove the cap. Pay Medicaid for using the drugs a higher rebate than the actual payment for the drug by Medicaid just seems a little strange.

CHAIR THOMPSON: Yeah. That's what I'm struggling with a little bit too, just because it seems like what we're using as Medicaid as a mechanism to achieve other policy objectives, not as a way to achieve Medicaid-specific policy objectives. That's the place where I'm

having difficulty.

I get how it's a convenient place, and certain policymakers might want to use the rebate program in that way because it's a vehicle for achieving those objectives. But they really aren't Medicaid objectives. They really are more general health care objectives.

Are we fairly characterizing that, Chris?

MR. PARK: That's correct.

CHAIR THOMPSON: Okay.

MR. PARK: I mean, generally, people want to raise the cap because they think it will exert downward pressure on inflationary pricing, and so that manufacturers will not raise prices as substantially over time as they have been.

CHAIR THOMPSON: But regardless of what manufacturers do, in the current environment, Medicaid is fully protected from those inflationary pressures, but other payers are not?

MR. PARK: That's correct.

EXECUTIVE DIRECTOR SCHWARTZ: Can I ask a question, though? Which is you all can decide what you think of this on its merits, but the reason we started in

on this area was concern about the level of spending. So I just want to -- that is a Medicaid issue as well. Maybe this is not your preferred approach to it, but maybe that's something that can be part of the discussion.

CHAIR THOMPSON: Yeah. In the sense that it creates savings --

EXECUTIVE DIRECTOR SCHWARTZ: Right, right.

CHAIR THOMPSON: -- and offsets other spending.

EXECUTIVE DIRECTOR SCHWARTZ: Yes.

CHAIR THOMPSON: Yeah. That's true. That's fine.

Okay. Sheldon, Fred, Chuck, Martha.

COMMISSIONER RETCHIN: Well, I thought I was following everything. Now I'm a little confused.

Maybe just start on -- in the grace period, I defer to others like Kit who have had more experience with -- it does seem like a longer grace period, notwithstanding that a breakthrough drug, it's still six months. I don't know whether we need some sort of fail-safe.

I'm more interested in removing the cap. For removing the cap entirely, listen, I'm not opposed to saving money, especially for the Medicaid program, but the

15-, $20 billion in savings over 10 years, that is not exclusively Medicaid, or it is? And Medicaid would be entering into the Twilight Zone of actually being paid, but is that --

MR. PARK: I will double-check with CBO as to what all went into their scoring.

COMMISSIONER RETCHIN: Yeah. So here's where I guess I am. I understand the asymmetry of the marketplace and pharmaceuticals. It doesn't function very well. Launch prices are already, in many cases, staggering, and then even with drugs that have been around a long -- we've had -- soon we'll have a $100,000 EpiPen.

So I guess that's what caught my eye is this ecosystem that had a crude marketplace. We don't know what we don't know, and that's why, I guess, I would be interested in a more graduated -- maybe there's a time limit, or we just come back to it, but I certainly am interested in raising the cap. I don't know whether 125 percent is the right number, but I do think we don't know what that might do of access, if I understand this correctly.

CHAIR THOMPSON: Fred.

COMMISSIONER CERISE: Well, a quick comment on -- I agree with the grace period discussions. I mean, I think giving states some time to figure that out, 180 days seems reasonable, given all the processes they have to go through.

On the rebate issue, Penny, I'm kind of following where you are on that. It just seems like I know there's stuff we need to do with prices or that need to be done with prices. It does seem that it can tend to cloud the issue if we're asking manufacturers to pay Medicaid to use a drug and some of the other pressure points or arguments you'll want to do around -- you know, if you want to do things on tighter formulary or negotiating elsewhere, it does seem to -- it doesn't feel right that you're saying pay Medicaid to use this drug, and I think it could take away from some of the other legitimate discussion points around drug prices where we need to make some progress.

I do have a question to follow up on Peter's comment about manufacturer's option to leave the market, and, Chris, you said there's a lot of other reasons why they wouldn't do that. And just to clarify, I mean, like on a drug-by-drug basis, if you're saying this one went up

and now they've having to pay to stay in Medicaid, they wouldn't opt-out and just say we're not participating in Medicaid with this drug.

MR. PARK: They can't opt-out for a specific drug. They're either in the program or out.

COMMISSIONER CERISE: They're in or out. Gotcha. All right.

CHAIR THOMPSON: Chuck and then Martha and then back to Kit, and then I'm going to go to the public after that, so we can get any of their thoughts to consider.

COMMISSIONER MILLIGAN: Thank you.

Nice job, Chris, as always.

I will be brief. I just wanted to align myself in support of Recommendations 1 and 2. I prefer the 180-day grace-period option for the reason that have been discussed.

And I think with respect to 3, I'm not personally prepared to kind of go there yet based on a lot of the concerns and questions that have been raised here. I do think we have to be attentive to pharmacy pricing issues, but I feel like we just don't have enough information on all of the consequences of this one to go there yet. So I

just wanted to kind of let the Commission know where I'm at.

COMMISSIONER CARTER: This is a little detail on the grace period.

Chris, I noted in comparing with other payers, this part about if a drug is in one of the six protected classes that Medicare is required to do an expedited review and render a coverage decision within 90 days -- and I know that we're not necessarily recommending that Medicaid match what Medicare is doing, but I just want to call out, in an abundance of caution, that the protected classes that would be applicable to Medicare wouldn't necessarily be applicable to Medicaid.

I know that's not where -- I don't think that's where we're going, but it needs to be said out of an abundance of caution.

CHAIR THOMPSON: Kit.

COMMISSIONER GORTON: So I just want to respond to this characterization of having to pay Medicaid to use the drug.

All of this is indexed off of what the manufacturer chooses as its price point. The situation is

if I choose to raise the price of my drug to this point, then the penalty that I will pay in Medicaid is this additional rebate, which could be -- but, again, it's the choice of the manufacturer. And I think the behavioral change that we're trying to prompt is to stop these huge inflationary jumps.

So I guess I don't feel that that's sort of, you know, we're going to charge you to -- the decision-maker in this case is always the pricing committee at the manufacturer.

CHAIR THOMPSON: Yeah. So this is good. Let's have this, a little bit of a debate, because I think that that will help us sort of sharpen this question.

I agree. I don't like that characterization of paying the program to use it.

I do think of it as a penalty, and maybe that is a way that we should be thinking about it, which is the behavior that we're concerned about, we want to disincentivize, but my question is what does it mean if we want to disincentivize a behavior, which we think is excessive price increases, when the Medicaid is already protected from all of the bad effects of that behavior.

That's what I'm struggling with, which is we can say, okay, it's bad. I mean, there might be actually some possible good reasons why you have certain inflation, but let's say it's all bad, and we say we don't want the program to suffer as a result of that bad behavior. But the program is already fully protected from that bad behavior, if that's what we think it is. That's the struggle that I'm having with it.

COMMISSIONER GORTON: So I'm not 100 percent convinced, and this may be because I'm ignorant, that the program is fully protected, because the rebates go to the states in most cases.

In some states, plans can get some supplemental rebates, but by and large, the rebate program is this dynamic between the manufacturers and the states.

So I'm not convinced -- and maybe Stacey has more insight -- that, in fact, when plans, which are now responsible for what? Two-thirds of the program? That plans, when negotiating with their PBMs – and some plans have good PBMs, and some plans have less good PBMs – that they always get the most beneficial pricing.

And I'm not convinced that the plans are 100

percent insulated from these inflationary increases.

And to the extent that the plans experience price pressure, which has certainly happened -- we have seen huge generic increased price pressure on the plan side and in the fee-for-service program, as well as inflationary pressure on the brand formulations. So if the plans experience that over a period of time, then in order to generate actuarially sound rates, the states have to pay higher capitation, and then the federal government has higher match.

So I'm not convinced that the insulation is perfect because we have this sort of covert --

CHAIR THOMPSON: Well, let's call the question because I think that the plans are -- we are supposed to be collecting rebates on what happens inside of the plans. It didn't used to be true, but it now is true. Is that --

VICE CHAIR LAMPKIN: No, that's true.

But I think the point that I'm hearing from Kit does make sense, which is that if the plan is not able to pay as aggressively as where the rebate is coming in at the cap, then not only do you have the cost, the incremental cost that the plan is paying for that drug, but also when

you're building that into the capitation rate, you're also paying the plan an underwriting gain, you know, load to the higher prescription drug price that they're paying.

So it is probably true that in states that use a lot of managed care that there is a perfect protection. It's more of a theoretical --

CHAIR THOMPSON: Okay, okay. Good, good. All right. So that is helpful.

Chris, is there anything that you want to comment on that point?

[No response.]

CHAIR THOMPSON: Yeah, Melanie.

COMMISSIONER BELLA: Going to Kit, your point about they're setting the price. I'm with Darin's kind of Whack-A-Mole thing. How do we -- how does this not just do -- why won't they just raise the price? I mean, I know that sounds so dense, but it seems fairly obvious that that's how they would respond.

COMMISSIONER GORTON: So this doesn't address Chris' presentation point. This doesn't address the introductory price level, the initial price that they set. This is America, and we don't set -- we don't control

prices.

But what this is, as I think Penny correctly characterized it, is it creates a penalty for aggressive increases in price post --

COMMISSIONER BELLA: Right. But could we drive Medicaid spending by increasing this incentive to set a higher launch price?

COMMISSIONER GORTON: They don't seem to need an incentive to set a higher launch price.

COMMISSIONER BELLA: Well --

COMMISSIONER GORTON: We're seeing that behavior already.

COMMISSIONER BELLA: Yeah, yeah.

COMMISSIONER GORTON: Pricing is always an arms race at some level, and so I think this is an incomplete response.

I don't think we ever get price equilibrium unless we approach it differently.

CHAIR THOMPSON: Yeah.

COMMISSIONER GORTON: I do think that this concept -- and maybe when staff redoes the rationale, we focus this on it as --

CHAIR THOMPSON: Yeah.

COMMISSIONER GORTON: -- a penalty for aggressive inflationary.

CHAIR THOMPSON: That would otherwise have this kind of negative effect on the program and potentially --

COMMISSIONER GORTON: Yes.

CHAIR THOMPSON: Yeah. See, that's the equation that I think we need to complete in order to feel I think widespread acceptance by the Commissioners on this point, although I sense a little bit of a split as it exists now. But I think that for those of us that are questioning this, we can be brought along with a better rationale along the lines that we've just been talking about.

Let me just pause for a second and open it up for the public to see if we have any additional insights or commentary that we should take into consideration before concluding this part of our session.

PUBLIC COMMENT

* MR. TURNER: Good morning. Thank you for the opportunity to comment. My name is Wayne Turner. I'm a senior attorney with the National Health Law Program.

I just wanted to comment on the pharmacy and

therapeutics committees. We've looked at these committees, and in many states, they really operate as a black box. There is wide variation among states in terms of public notice, public meetings, conflict-of-interest disclosures, and recusals. So if you're going to be codifying a grace period, that would really limit coverage, and a reliance on the processes of a P&T committee, you really need to look at the P&T committees first to make sure that those processes are open and have the opportunity for stakeholder engagement.

P&T committees, of course, are important in coverage exclusions through Medicaid formularies, if there is a clinical equivalence and the explanation is offered in writing.

Again, this kind of information is really difficult to access in many states, and states that you wouldn't necessarily consider difficult to access.

The final thing is P&T committees really need to be engaging with the medical care advisory committees and other kind of stakeholder entities, including the long-term services and support stakeholder committees that were established under the new Medicaid managed care regs.

So I would just urge you to urge CMS to standardize P&T committees and their functions and operations so that we have an open and transparent process.

CHAIR THOMPSON: Thank you.

I think that's an excellent point and something that we at least can address in commentary as we talk about this.

I there is -- the logic of just saying we're putting a lot of dependency here on these committees and therefore we need to really pay attention, I'm not sure, Chris, how much more by next meeting that you can bring forward on that question. And it may be worthy of its own sort of assessment in our next agenda of issues, but we can at least raise that as something that obviously requires some attention and deserves some scrutiny.

Any other comments from the public?

[No response.]

CHAIR THOMPSON: Any final comments from people who have not been heard from?

COMMISSIONER SCANLON: I would just echo what you just said about focusing on this because for me, sort of the entire process, if we're starting a clock and we're

going to have a clock that has -- I'm leaning toward the 180 days because I'm worried that the clock is going to start and not everybody is going to know about the clock or there's going to be information gaps and lags, et cetera.

So if we're imposing any requirements, you need to figure something by end date, that the process be structured in a way that that's a fair assumption, that you can accomplish that by an end date.

CHAIR THOMPSON: Alan.

COMMISSIONER WEIL: I'm comfortable with these. I came in thinking I was supporting 90. I don't have great wisdom.

But apropos of not just the last comment, but I think it's hard to look at these. This is always the challenge we face. It's hard to look at this in the abstract. I mean, the fact is, as we know from the materials, there are ways around these dates, and so it -- I don't want to say it doesn't matter whether it's 90 or 180, but there are ways to set up barriers that are totally legal, even if you amend Section 1927(d)(1)(B). And so I wonder how important it is. I think it's a good statement to say that it takes time to evaluate, but it doesn't mean

coverage is going to hit at that point.

And, similarly, I think the comment, not just about P&T, but in general we've got states that are looking at ways to try to think about formularies and preferred drugs in more aggressive ways to try to get price negotiation. The interplay between that and this seems important.

So a long way of saying I'm fine with the recommendations, but I think they are sort of looking at a corner of a bigger problem that we've spent some time on that's probably more consequential.

MR. PARK: Before we wrap up, just in terms of -- it seems like the Commission is, more or less, comfortable with 180 days for the grace period.

I wasn't quite as clear as to --

CHAIR THOMPSON: Yeah.

MR. PARK: -- recommendation in terms of like whether or not we should tie some kind of coverage requirement at the end of the grace period.

So if people have strong feelings one way or the other on that, it would be helpful.

CHAIR THOMPSON: Let me make a suggestion about

how to proceed, Chris.

So I do think that we need to come back with the idea of voting on recommendations at the April meeting.

I think it sounds like we have a general consensus around 180 days.

It doesn't seem to me that we have a lot of consensus around the second recommendation. I do think that is something that we could potentially discuss, again, in commentary to our recommendation that there could be some triggers.

But I agree that with most of, I think, the Commissioners here that it seems a little arbitrary for this particular trigger, but I do think that that's something states could do for themselves to set up that.

I agree as well that we need to establish some statements about the importance of P&T committees and the way that they operate.

So unless we have a strong objection from the Commissioners, that's what I would like to see for the next meeting, and then I think with regard to the rebates, let's bring it back for a vote. We'll see where we end up.

I do think that we need to sharpen this point

that we had some dialogue on this morning about the extent to which the program is currently protected from aggressive inflationary pressure and how this step might address that.

There is some, I think, difference of opinion about 125 versus just lifting it. I think we could potentially discuss that more at the next meeting based on the rationale, and I think having the clarification that you describe from CBO would be helpful for that too, knowing whether or not the savings, in general, are particularly to the Medicaid program.

My sense is that most of the Commissioners may feel more comfortable, at least at this stage, of going to 125, but that's something that we could vote on both ways. So we can talk a little bit about how to bring that to a recommendation.

Chuck.

COMMISSIONER MILLIGAN: If part of the work between now and April is whether the program is sufficiently protected, I do think it's important to keep Kit's point in mind with the discussion with Stacey whether by program we mean --

CHAIR THOMPSON: Yes, yes.

COMMISSIONER MILLIGAN: -- kind of all of the incentives through the program --

CHAIR THOMPSON: Absolutely.

COMMISSIONER MILLIGAN: -- because of this potential arbitrage kind of issue, so I just think --

CHAIR THOMPSON: Absolutely, yes.

COMMISSIONER MILLIGAN: Okay.

CHAIR THOMPSON: I think that's exactly what we mean by that. Right, exactly.

COMMISSIONER MILLIGAN: Okay.

CHAIR THOMPSON: Okay, great. Thank you, Chris.

Thanks, Commissioners.

Hi, Kate. Welcome. Now we'll talk a little bit about therapeutic foster care.

MANDATED REPORT ON THERAPEUTIC FOSTER CARE: REVIEW OF DRAFT CHAPTER AND POTENTIAL RECOMMENDATIONS

* MS. KIRCHGRABER: Good morning, Commissioners. I'm pinch-hitting for Martha who couldn't be here today and just want to make it clear she wrote the memo, she wrote the chapter. I've been working alongside her, but she really did all the hard work and heavy lifting here.

So, today, we're going to continue the Commission's discussion of therapeutic foster care that we began last September.

I'll start by reviewing the congressional request that precipitated this work and then provide a brief overview of therapeutic foster care and Medicaid coverage of therapeutic foster care services.

I'll then review some considerations for a uniform definition before describing potential Commission responses.

So in the report accompanying the fiscal year 2019 Labor, Health and Human Services, and Education appropriations bill, the House Appropriations Committee requested the MACPAC examine therapeutic foster care. They requested that within 12 months (or the end of September) MACPAC conduct a review for the development of an operational definition; examine the advantages of uniform definition; and include a list of potential services to treat mental illness and trauma that would be within the scope of such a definition.

And, Commissioners, you have in your materials the draft chapter for the June report, which would serve as

our response to this congressional request.

So the chapter begins with an overview of therapeutic foster care. The term "therapeutic foster care" refers to the practice of serving children and youth with serious emotional, behavioral, mental health, or medical conditions in a family-based setting rather than in an institutional or group setting.

The practice is often viewed as a more intensive form of foster care, although children outside of the child welfare system may benefit from and receive these services.

For example, a child who has severe behavioral health needs might benefit from temporary placement in therapeutic foster care, but they haven't been removed from their biological family by a child welfare agency.

There's currently no uniform definition of therapeutic foster care, but there are a number of common elements. The services provided under the practice typically include crisis support, behavior management, medication monitoring, counseling, and case management.

Children in therapeutic foster care receive an individualized treatment plan, and their treatment team meets on a more frequent basis than children in standard

foster care situations.

Foster parents serving these children receive higher levels of training, payment, and caseworker support than other foster care parents and are considered part of the treatment team.

Many states have multiple levels of therapeutic foster care, with payment levels to families depending on the child's need.

The chapter also provides a discussion of Medicaid coverage of therapeutic foster care services. States have typically chosen to cover therapeutic foster care services under the Medicaid state plan either as a rehabilitative service or as targeted case management, although some states have adopted therapeutic foster care through waivers.

Whether or not these services are explicitly covered in a state plan as a therapeutic foster care service, clinical and therapeutic services that comprise the practice may still be billed to Medicaid.

For example, a state may provide case management services under the state plan but not label them as therapeutic foster care services.

Some states are more prescriptive in their Medicaid services that they pay for, limiting the benefit to certain types of therapy, while others view the benefit more broadly.

Some components of therapeutic foster care cannot be covered by Medicaid. These include room and board and training and supervision of therapeutic foster parents. States cover these usually with state-only funds or federal child welfare funds.

The chapter concludes with a discussion of the consideration for a uniform definition and whether a definition would address the concerns expressed.

In its request to MACPAC, the House Appropriations Committee suggested that a uniform definition could result in more consistent care. Some stakeholders share this view and think that a uniform definition could also help improve the quality and professionalism of therapeutic foster care services.

Establishing a uniform definition could lead to states covering a more consistent packet of services. If therapeutic foster care was added as a mandatory benefit all states would be required to cover the defined services.

If it's added as an optional benefit, states would not be required to cover therapeutic foster care, but covering the benefit could provide some administrative simplicity. States wouldn't have to piece together therapeutic foster care from targeted care management or rehabilitative services.

At the same time, states don't always adopt the options provided to them and may view their current approach as the most appropriate for their circumstances.

And whether or not the definition is defined in statute as mandatory or optional, EPSDT would apply. States would continue to have the flexibility to set medical necessary criteria and amount, duration, and scope of the benefit.

A uniform definition of therapeutic foster care may improve the ability of states, federal agencies, advocates, and researchers to assess access to and quality of these services.

The provision of therapeutic foster care in Medicaid has not been widely studied, and given the various ways that states have implemented their programs, it's really difficult to develop a complete understanding of the

services provided and the children and youth who receive these services.

A uniform definition could provide an avenue for future research into the quality and effectiveness of therapeutic foster care interventions and monitoring access and compliance with standards of care.

On the other hand, simply having a uniform definition in Medicaid would not address other concerns regarding the availability and quality of therapeutic foster care, including the need for highly skilled and committed caregivers. Medicaid can't pay for recruitment or training of foster parents.

A uniform definition of therapeutic foster care also wouldn't address coordination across agencies. Children who need or are already receiving therapeutic foster care services are typically served by multiple agencies, which could include Medicaid, child welfare, juvenile justice, behavioral health, and education.

Collaboration across all these agencies is important, given the complex needs of the children involved, but a uniform definition of Medicaid wouldn't address that.

A uniform definition might also have unintended consequences. For example, a more prescriptive definition in the statute or regulations, such as describing specific services or qualifications of providers, could restrict existing state flexibility. It could limit the services provided to children or prevent them from receiving the services that meet their unique needs.

A uniform definition would also need to be structured to account for future practice changes as evidence-based therapeutic foster care practices evolve. As additional knowledge is gained regarding the needs of these children, the particular approaches to providing services and the outcomes associated with specific methods, a uniform definition may prevent state Medicaid programs from responding to the evolving evidentiary base.

So moving on to potential Commission responses, the Commission does not need to make formal recommendations to respond to this request. It could simply comment on the advantages and disadvantages of uniform definition of therapeutic foster care and what that might mean for beneficiary states and the federal government.

If the Commission would like to consider a

recommendation, it could recommend that a uniform definition of therapeutic foster care be established either in statute or regulations.

The Commission could also recommend that the Secretary issue sub-regulatory guidance on therapeutic foster care. Further direction from the Secretary could help provide clarification to states on how they can use existing flexibilities to design the benefit without adding a new benefit in statute or regulations.

Instead of making a formal recommendation, the Commission could also describe how state flexibility in the design of benefits has led to variation in the provision of therapeutic foster care and how this variation might provide lessons to other states on how to approach the benefit.

So that concludes our slides, and I look forward to the discussion on the draft chapter and potential recommendations, so thanks.

CHAIR THOMPSON: Thank you, Kate, and thank you for being such a great pinch-hitter.

All right. We'll start off with Peter, and then we'll go to Martha and then Chuck.

COMMISSIONER SZILAGYI: Thanks, Kate, that was well done, and thanks in absentia to Martha.

I think this is an excellent chapter, and just the bottom line is I agree that we should probably not recommend a uniform definition of therapeutic foster care for the reasons that you state.

I mean, I wish it was easy. It's easy to define who's in foster care. It's really difficult to define who should be in therapeutic foster care because of these needs. So it's difficult to define at this point the children who should have special -- who should have these special therapies.

Secondly, it's really difficult to define what the management should be, and that field is evolving very quickly. And I'm going to give a couple examples of that.

Because the population is difficult to define and then the management is difficult to define, it really, I think, would be very challenging to create a uniform definition, and there may be unintended consequences if we create a floor of management and some states want to go higher than the floor. There may be some unintended consequences.

So I like the concept of clarifying guidance, and I really like the idea of potentially pointing out some best practices or lessons from states. There's already some of that in the chapter, but I think that could be beefed up and maybe a little bit of an eye to the future.

I'm going to give you a couple of examples. Among the experts in therapeutic foster care, it is becoming clear that one of the most common problems for kids in therapeutic foster care is a diagnosis called "developmental trauma disorder." It's also called "complex childhood trauma" or "severe toxic stress." There's not even an ICD-9 code for it yet, but the experts are kind of converging toward this as one of the fundamental problems for these children. And they need a special package of therapies which involves trauma-focused care, but it's hard to track it. It's hard to define it yet, and the management is evolving, although it's clearly the evidence-based management, which is trauma-focused care. But it would be hard to define.

Another example is parent training. So, as you mentioned, foster parent -- or biological parent training is actually provided by Title IV-E, Social Security Act,

not by Medicaid. But there's a whole variety of parent training programs out there, but there are a few evidence-based parent training programs. So the chapter could highlight a few evidence-based parent training programs, even though Medicaid may not pay for that. So I think that would be a helpful addition to the chapter.

And one final point -- and this isn't for this chapter, but I think it would be helpful for the future for us to weigh in whether it's an issue brief or a potential chapter about the Families First legislation.

This is potentially transformational by trying to move upstream and help kids be maintained in biologic parent homes rather than foster care by shifting services upstream. States are having great difficulty even interpreting what this legislation is all about, how you can deal with it, and how it can potentially achieve the purposes of maintaining stability within biological homes rather than foster care.

So I think just for the future -- this is off the point of this chapter, but for the future, I think that might be sort of a helpful thing for us to weigh in.

CHAIR THOMPSON: Peter, let me ask you. So in

terms of thinking about whether we're issuing -- we're suggesting that HHS issue guidance. Do you think states are missing -- I'm trying to think about whether this is guidance or resource books or something that -- generally speaking, when we talk about a federal agency issuing guidance, it's sort of with the idea that they know the answers, and here's what you can do as opposed to maybe something that looks more like we want to make resources available, we want to keep communication open amongst states that are trying to address these issues.

COMMISSIONER SZILAGYI: I think it may be the latter.

CHAIR THOMPSON: Yeah.

COMMISSIONER SZILAGYI: So I think rather than --

CHAIR THOMPSON: So maybe we should think --

COMMISSIONER SZILAGYI: Because guidance is almost sort of definitional.

CHAIR THOMPSON: Maybe that's something for Commissioners to comment on. We can play with language here.

All right. So we've got Martha, Chuck, Toby.

COMMISSIONER CARTER: Peter, I think you helped

me some.

My question was, what is the problem we're trying to solve? This is a new topic for me, and I don't quite understand what the problem is. And, therefore, it's hard to come up with a solution. So any help anybody could give me?

CHAIR THOMPSON: Peter, go ahead. Why don't you just jump in.

COMMISSIONER SZILAGYI: I think the fundamental problem is there is clearly a mismatch between the needs of many children in foster care and many children who are in therapeutic foster care and the help that they are getting and the therapies, the management, the home-based help, the help that foster parents are getting, the types of mental health therapies. Many kids are on medications; they may not need to be on medications. Many kids are not on medications that they do need to be on. So I think the problem is the mismatch between the needs of the population and the care.

The challenge for me is that I don't think a therapeutic -- I don't think a specific definition would help us address that problem.

CHAIR THOMPSON: And then the question is, what part does Medicaid play in helping reduce that gap? And are we at a stage where something like a defined benefit is the thing that will help that?

It seems to me like what, Peter, you're suggesting and I think what the evidence that the staff have collected is, this needs to be a subject of conversation. People need to be paying attention to these families and these children, and people need to be also trying to organize services and supports in a way that makes sense using Medicaid.

But there might be a variety of different ways in which that could happen, and we're probably not at the stage where we want to prematurely constrain and define that in a way that might inhibit what actually needs to happen, whether that's important what needs to happen. And, Peter, that's a -- okay.

Chuck and then Toby.

COMMISSIONER MILLIGAN: So I think about this partly from a continuum of care perspective, and I'm wondering. I have a few questions, Kate.

When I think of therapeutic foster care, I'm used

to calling it "treatment foster care."

MS. KIRCHGRABER: That's also an acceptable --

COMMISSIONER MILLIGAN: Thank you.

I think that it is an important treatment modality. I worry about when kids age out of it, quite honestly, because I think that to me, one of the measures of success is not just kind of treating the child or adolescent in the moment, but also preparation for aging out of the foster care system or aging out of EPSDT eligibility, depending on all of those components.

How much do we know about the extent to which from a quality perspective or a definition perspective, preparation for kind of being emancipated or the eligibility cliff -- how much do we know about what makes for a successful TFC treatment?

MS. KIRCHGRABER: I don't think we've looked at that issue specifically, but similar to the problem of getting your arms around the definition, these services are all available to a child as long as they're eligible for Medicaid. So if it's through age 21, former foster care kids can get Medicaid longer than that, up to age 26.

So the services they can already get under

Medicaid, they can still get, whether or not it's being called therapeutic foster care. What states have done to sort of ease the transition, we would have to look at that. We haven't really looked at that aspect.

COMMISSIONER MILLIGAN: And, again, I'm going to sort of stay on the kind of care continuum piece of this because this is at the kind of very intensive end of that, and I think of it, in some ways, analogous to IMD or other -- where there can be providers who are like doing it because it's God's work and there are providers who are doing it as a sustained revenue source with long lengths of stay, and so do we know much about lengths of stay? Because I think part of it for some providers who are not doing it for God's work, they're, in some ways, working back through the court system, through the foster care agencies, to almost keep the revenue stream going to the provider. And I wonder if underneath this question of defining criteria is work toward almost discharge planning from that kind of perspective.

MS. KIRCHGRABER: I think what we know about the genesis of this request is that it was more on the quality side. That if you define it, you can quantify it. You can

regulate it and have a better sense of the quality of the services that are being provided.

I think the movement and certainly the Families First bill is moving towards not putting people in congregate settings and getting kids out of foster care I think even faster than what we're currently doing.

I think the goal obviously always is as brief as possible. I don't know that we've really looked at what states are doing or what the average length of stay is.

COMMISSIONER MILLIGAN: And I doubt it that we would have it. I just was curious because I do think that there are anecdotal stories of really quite long lengths of stay, and then the child hits their 18th birthday or their 21st birthday, and they lose the service entirely and are completely unprepared.

My last question is, are you aware of whether there's any other body, accreditation entity, licensing entity, anything like that that is working on defining TFC criteria, sort of external to the Commission, external to state Medicaid agencies or CMS? Is anybody else working on kind of accreditation or other related criteria?

MS. KIRCHGRABER: There's an organization -- I'm

trying to think of it -- it's the Foster Family-Based Treatment Association. They are ones who have expressed interest in that. I don't know how far along they are in any kind of process, but they're the only ones that I know of.

COMMISSIONER MILLIGAN: Thank you, Kate.

CHAIR THOMPSON: Toby, and then, Leanna, I want to see if there's anything that you want to add to this conversation as well.

COMMISSIONER DOUGLAS: Great job on the chapter.

My comments relate from experience in California when we had to implement therapeutic foster care. I mean, there was a lot of confusion on what was covered, and so I think it's important to separate the issue around guidance into what's -- from a Medicaid lens, what's the guidelines on what could be covered and how. And I do think that not creating any set definition is clearly needed because of just how each state has implemented, so it varies, and we don't want to change that.

But there's also not clarity on what's the IV-E requirement, so where does the child welfare come in, and what should be covered under the child welfare system

versus what is Medicaid's responsibility? So clear guidance on that and separating that from, okay, well, then what's the definition of how it should be delivered, and what are the key -- from a continuum and the key components of it? That's a whole -- I could see best practices and different tools.

But some clear guidance from CMS on how it should -- what ways that you can cover it, and what is claimable under a state plan versus waiver, and where does IV-E cover certain benefits? And how can you actually blend the two together? If you can, it would be helpful because it was a struggle at the time in California for getting clear guidance on that.

CHAIR THOMPSON: So your point, Toby, is that actually the -- I was questioning whether we're suggesting guidance or not. Really, there is not so much about this is what therapeutic foster care is, but kind of here is what can be in your view --

COMMISSIONER DOUGLAS: Yeah.

CHAIR THOMPSON: -- and what cannot be in your view, just in terms of claimable versus not.

COMMISSIONER DOUGLAS: Yeah.

CHAIR THOMPSON: And then inside of that space that's in between, some support for best practices and research and conversation among the states --

COMMISSIONER DOUGLAS: Yeah. And I think it gets back to this question of what the problem is.

CHAIR THOMPSON: Yeah, yeah.

COMMISSIONER DOUGLAS: There's different definitions of the problem. To me, the problem is there's no clear -- there's not clarity. From a Medicaid lens, if I'm a Medicaid agency, I don't know --

CHAIR THOMPSON: What I can and cannot do, right.

COMMISSIONER DOUGLAS: -- what I can and cannot do on this.

And then there's a separate problem, which is more the child within the foster care system and how we best address their needs.

CHAIR THOMPSON: That's helpful. Yeah.

COMMISSIONER DOUGLAS: But my question is I don't know as a Medicaid what I can actually fund and if it's really my responsibility versus the child welfare agency.

CHAIR THOMPSON: Peter, were you going to jump back in?

COMMISSIONER SZILAGYI: Can I just ask something? Because that really helped me, Toby.

Just to follow that concept, so in terms of parent training, whether it's foster parent training or biologic parent training, the guidance could be that it's not Medicaid that pays for this. It's Title IV-E that pays for this.

The sort of best practices could be that there are two programs that are clearly evidence-based, Parents as Teachers and Incredible Years.

Just to give an anecdotal example, in Monroe County, where I was for 30 years -- and actually, in disclosure, this is my wife who did this -- there were 52 different parent training programs about 10 years ago. Some of them were really fly-by-night, and several of them were really more evidence-based. Medicaid and child welfare in Monroe County, New York, worked together to only for child welfare fund two programs -- Parents as Teachers and Incredible Years.

And the really good programs retaught their staff to do Parents as Teachers and Incredible Years, and that kind of streamlined and made much more effective training

for foster parents and biologic parents. So that was just a concrete example of how a chapter could have both some guidance about who could pay what and then some best practices.

CHAIR THOMPSON: All right. Leanna, I want you to jump in here.

COMMISSIONER GEORGE: I just want to point out also that not every -- consider who is at risk of being investigated or reported to CWS, Child Protective Services, I know with Serenity, we had like three or four cases a year reported on us for very minor things. Serenity has very profound disabilities, and it's a very intensive situation with her.

So to me, families are on that edge of we need help, but we're not so bad off that we need foster care. We're trying our best to hold it together, but we have no other supports, networks.

The best thing that has ever happened for Serenity is she went to a two-year program at Murdoch Developmental Center in North Carolina called the PATH program, and the one thing that I think it so critical in any of these temporary programs, whether it's therapeutic

foster care or for institutional programs or as a temporary basis in nature like the PATH program is -- is the transition piece going back into the home. The goal for foster care, the goal for our children is always reunification back into the community environment as much as possible, to bring them back home where their natural supports love them so much.

I think one of the biggest pieces that has been missing in a lot of areas is that parent training piece. Train the parents to almost therapeutic levels to be able to provide the behavioral supports that are needed, to wrap around the parents and the family during that transition process, to provide coaching and mentoring so that they can see how it works in action, so that they can implement it in the home when those supports have faded away. So, eventually, the support should be faded, correct?

I just think that's a big critical piece. That is not just for therapeutic foster care, which is sort of very important, but for so many families with children with significant, cognitive, functional behavioral, mental health challenges, whether it's autism or any litany of other challenges that our children face.

CHAIR THOMPSON: Thank you.

Okay. Before we close this off, Kate, with some guidance back to you, we'll see if the public have any comments that they would like to make on this subject.

PUBLIC COMMENT

* MR. MARTIN: I'm glad I could be here. I'm Ryan Martin with the Senate Finance Committee. Chairman Grassley is excited to hear this. I know this is a House Appropriations request, but I think the context here was great about there is a focus on moving children from group care into homes, and there's a question about what's available and by who, and so how can there be services provided to those folks? What are they eligible for? What can states provide, so that these kids can live in a family-like setting, when possible? So I think that context is really great.

So I'm looking forward to reading the chapter.

CHAIR THOMPSON: Thank you so much.

Okay, Kate. So I think that we've given you some feedback on the chapter and maybe opening the aperture a little bit on that to make sure that we're taking some of these -- the larger view about what's happening to these

families and children before we focus down on therapeutic foster care specifically.

I think we are convinced that we probably need to have a recommendation around guidance and around best practices and how to develop evidence and how to promote collaboration between Medicaid and foster care. So I think if you can work on those kinds of things, I think some of the points that Leanna has made, that Chuck has made, that Peter has made obviously, to continue to strengthen the chapter and the information that we're providing around this important subject.

Thank you so much for all the great work on this topic.

MS. KIRCHGRABER: I'll tell Martha.

CHAIR THOMPSON: Okay. Let's take a break, and we'll be back at 11:10 to talk about third-party payment.

* [Recess.]

VICE CHAIR LAMPKIN: Heads up. One minute, folks. One minute, folks.

[Pause.]

VICE CHAIR LAMPKIN: Okay, great. We're back, and we held one DSH topic out to consider on its own. So

Rob is going to take us back to DSH.

TREATMENT OF THIRD-PARTY PAYMENT IN THE DEFINITION OF MEDICAID SHORTFALL: POTENTIAL RECOMMENDATIONS

* MR. NELB: Thanks, Stacey.

So this morning, we're going to talk about some potential recommendations that you may want to make around the treatment of third-party payment in the DSH definition of Medicaid shortfall.

This is a topic that's sort of separate from some of the DSH allotment issues that are going to be included in the Commission's upcoming March report. So we held this out for future consideration at this meeting.

So I'll begin today with some background on the DSH definition of Medicaid shortfall and then review the effects of a recent court ruling that changed how Medicaid shortfall is calculated for patients with third-party coverage.

I will focus today on two different types of third-party coverage situations -- first, Medicaid patients who are dually enrolled in the Medicare; and second, Medicaid patients who are also enrolled in private

insurance coverage.

Then I'll walk through three different policy options that the Commission could consider and discuss. The potential effects of these options on states, providers, and enrollees.

Finally, I'll review next steps for voting on recommendations if the Commission is interested in making recommendations on this issue in its June report.

So, first, some background. As you know, DSH payments are statutorily required payments that help offset hospitals' uncompensated care costs.

DSH payments to an individual hospital cannot exceed what's called the "hospital-specific limit," which is defined as the sum of a hospital's uncompensated care costs for both Medicaid and uninsured patients.

Uncompensated care cost for Medicaid patients, referred to as "Medicaid shortfall," is defined as the difference between a hospital's costs of serving Medicaid-eligible patients and the payments that the hospital receives for those services.

This definition, though, gets a bit complicated for Medicaid patients with third-party coverage because

hospitals receive payments from both Medicaid and other payers for these patients.

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 2010, CMS issued sub-regulatory guidance clarifying its position that third-party payments and costs should be counted in the Medicaid shortfall calculation, and it finalized this policy through regulation in 2017.

Once the new DSH audit rules were being enforced, several hospital associations challenged CMS on this issue, and in March of 2018, the D.C. federal District Court sided with the hospitals on this issue, concluding that third-party payments cannot be counted in the shortfall calculation because they are not explicitly mentioned in the DSH statute.

CMS is appealing this decision, but in the interim, it has withdrawn its 2010 guidance and stated that it's not enforcing the 2017 rule at this time.

So this table illustrates what's counted and what's not in some of these different approaches to

calculating Medicaid shortfall.

Under CMS's 2010 policy, all payments and costs for patients with third-party coverage are counted. However, under the court ruling, third-party payment costs are counted, but third-party payments are not.

At the bottom, I highlight another alternative approach that several states were using before the DSH audit rule, which is to just not count payments or costs for patients with third-party coverage, and instead just to count Medicaid shortfall for Medicaid-only patients.

So this court ruling plays out differently for different types of third-party coverage situations. So let's first look at how it affects Medicaid shortfall reported for patients who are dually eligible for Medicare and Medicaid.

For these patients, Medicare is the primary payer for hospital services, but Medicare payments are often below hospital costs.

Under CMS's 2010 policy, hospitals could receive DSH payments for the costs that Medicare did not pay.

Under the court ruling, however, hospitals can also receive DSH payments for costs that Medicare pays for.

As you know, there are several different types of dually eligible patients. Some receive full Medicaid assistance with Medicare cost sharing, and some only receive assistance with Medicare premiums.

Because hospitals do not submit Medicaid claims for enrollees who do not receive assistance with Medicare cost sharing, these patients typically are not included in DSH audits. These are the specified lower-income Medicare beneficiaries and the qualified individuals, which is about 1.6 million duals.

For individuals who do receive Medicaid assistance with Medicare cost sharing, Medicaid often doesn't pay the full cost sharing amount. In this case, any low-payment Medicaid payment of Medicare cost sharing is counted as uncompensated care on DSH audits.

So this figure illustrates the amount of Medicaid shortfall reported under two different methods, and in this example, we used the cost of an average Medicare inpatient stay, which was about $13,000 in 2015. In that year, Medicare paid hospitals on average 92.4 percent of hospital costs, resulting in an average shortfall of about $1,000.

If Medicare payments were not counted, the amount

of shortfall that the hospitals would report would be much higher, $11,900 in this example.

In both scenarios, we assume that Medicaid is paying the full inpatient hospital deductible, which was $1,260 in 2015; however, if Medicaid paid a lower amount, the amount of Medicaid shortfall would increase in both scenarios.

Now turning to Medicaid shortfall for Medicaid patients who also have private insurance coverage. The effect here is a bit different because, privately, private insurance payments typically exceed hospital costs.

In 2016, for example, the American Hospital Association Annual Survey reported that private insurance payments averaged about 144.8 percent of hospital costs.

Under CMS's 2010 policy, any surpluses that a hospital received for Medicaid patients with private coverage would reduce the amount of DSH payments that the hospital could receive for Medicaid-only patients.

This policy particularly affects hospitals with neonatal intensive care units because low-birth-weight babies are deemed eligible for SSI and as a result are automatically eligible for Medicaid. These patients are

often very costly to treat and have long hospital stays, and once you add up the private insurance payments and costs for these patients, just a few low-birth weight babies can have a very significant effect on the total amount of shortfall that the hospital reports.

At our last meeting, you asked about deductibles and copays for patients with private coverage. If a patient doesn't pay their cost sharing at the time that the DSH audit is conducted, these bad debt expenses are reported as uncompensated care costs and are eligible for DSH funding.

So this table illustrates how different methods of accounting for shortfall affects the total shortfall reported for patients, for Medicaid-eligible patients with private coverage. In this case, we're using an example from one of the Children's Hospitals that was included in one of the recent court filings.

In 2013, this hospital received $33.7 million in private insurance payments for Medicaid-eligible patients with private coverage, which is about $13.1 million above the Medicaid-allowable costs for these patients.

Under CMS's 2010 policy, this surplus would be

subtracted from the $16.4 million in Medicaid shortfall that the hospital reported for Medicaid-only patients, resulting in a total shortfall of just $3.3 million.

In contrast, under the court ruling, the private insurance payments would not be counted, and so the total shortfall would be much higher, $37 million in this example.

Another option would be to only count the Medicaid shortfall for Medicaid-only patients, which would result in total shortfall of $16.4 million, which is between that of the other options.

So this court ruling doesn't affect state DSH allotments, but it does have some different effects on state and hospital DSH spending.

Specifically, the ruling is expected to increase DSH spending in states with unspent DSH allotments because now the amount that they can pay an individual hospital is increased, and second, the court ruling may result in a redistribution of DSH funding in states that base their DSH payments on hospital uncompensated care costs, which was about half of states when we most recently looked at this.

We are beginning to see some of these effects in

states that were among the first to file lawsuits on this issue, and we expect to see more effects in the coming year, now that CMS has clarified that the 2010 policy no longer applies.

So to mitigate some of these effects, the Commission could recommend statutory changes to the DSH definition of Medicaid shortfall.

In your memo, we did present three different options. First, Congress could specify that all payments and costs should be counted for Medicaid patients with third-party coverage, which would be the same as CMS's 2010 policy.

Another option is that Congress could specify that payments and costs for Medicaid patients with third-party coverage should not be counted, and that instead CMS should only count Medicaid shortfall for Medicaid-only patients.

And finally, Congress could implement a hybrid of these two options and establish different rules for different types of third-party coverage situations; for example, covering the shortfall for Medicare patients but not counting the surpluses for the patients with private

insurance coverage.

All of these options are expected to minimize some of that large redistribution of DSH funding that's expected because of the court ruling, but they will still affect different types of hospitals differently.

Specifically, Option 1, reverting to CMS's 2010 policy, would result in a positive Medicaid shortfall for Medicare patients and a negative Medicaid shortfall for privately insured patients.

In theory, this policy may help offset low Medicaid payment of Medicare cost sharing and as a result may help improve access for some patients who are dually eligible for Medicare and Medicaid.

However, as I've highlighted, this policy may reduce or even eliminate DSH payments for some hospitals that serve high-cost patients with private insurance, such as some Children's Hospitals.

Option 2 would only count Medicaid shortfall for Medicaid-only patients. This approach is administratively simpler, and it avoids some of the complications that arise with Medicaid payments with private insurance coverage.

For example, as it is now, if a hospital enrolls

– a privately insured patient into Medicaid while they're hospitalized, the surplus that the hospital receives for those patients reduces the DSH payments that the hospital is eligible for.

And lastly, the effects of Option 3 are between those of the other options and so that depend on which rules apply to which situations.

So that concludes my presentation for today. If the Commissioners continue to be interested in making a recommendation, we can prepare a decision memo no the preferred option for a vote at the April meeting.

At the April meeting, I also plan to present a draft chapter that will accompany any recommendations and describe the Commission's analyses of these issues and any other points you'd like to highlight.

Thanks.

VICE CHAIR LAMPKIN: Thanks, Rob. That was great.

I think from the previous conversations we've had on this topic, the Commission has been very interested in pursuing some sort of remediation to the environment that the court ruling has produced.

You have given us a little foreshadowing of some of the complexities, but coming back today with some details around it has been enormously helpful.

And I want to particularly compliment you on your choice of graphics and tables to help illustrate those points because I think that you've made it all very clear in the materials and the slides, so thank you for that.

Does anybody want to ask questions or comments?

Alan.

COMMISSIONER WEIL: Aside from hating the term "Medicaid shortfall" because it implies that the costs are appropriate -- but I've said that before -- this is really terrific, and I think it does follow on a sense that where we're left after the court ruling is just nonsense, and so now the question is what's the best, given that the current makes no logical sense.

As I went through the logic, I'm drawn to Option 2, and I'll sort of present -- and I -- and it would be interesting, your take on it, and my fellow Commissioners. It all comes back to what we're trying to do if we take shortfall as a meaningful concept. Then the asymmetry between underpayment and overpayment seems very

problematic.

The notion that -- and I was very glad you mentioned -- it's a sentence, but it came very strongly in my mind. The disincentive to enroll a child in Medicaid due to the financial consequences of the hospital is not something I take lightly. I think we should take that very seriously, the notion that you're -- and again, it's not about good people/bad people. It's just that is a -- that feels like a very negative incentive to create, and that incentive is inherent in a policy that counts the private as an overpayment, if you will. That was a big red flag for me.

In part because of my discomfort with the concept of underpayment, when you're looking at duals, we might want to say Medicare has some rationale for the payment levels it chooses, and so maybe that isn't a Medicaid underpayment if the appropriate payment is Medicare is not the cost.

Anyway, I end up with a sort of simple thought, which is Medicaid is a payer of last resort. This is underpayment for Medicaid patients. You're not a Medicaid patient if you have another form of insurance. You're a

whatever patient, and Medicaid is filling in or offsetting, but the whole premise of being the payer of last resort is that we are not the rate setter for patients that have any other source of coverage. The rate setter is the other payer, and the state policies to piggyback on Medicare payment levels to eliminate the infill, I think is an expression of that.

Where we are is untenable. The risk of putting a hospital in position of feeling like if they enroll someone in Medicaid, they're going to take a financial hit, and the sort of conceptual frame of Medicaid leaves me with we only count this for people who are Medicaid only. That's where the logic took me.

VICE CHAIR LAMPKIN: Thanks, Alan.

Bill.

COMMISSIONER SCANLON: Yeah. I appreciate Alan sort of bringing up the issue of what should be the total cost, and I don't have to repeat that since I've done that so many times. I'm sure that you're becoming intolerant of my making that point.

I agree, too, that the current situation just does not sort of make sense. This idea that not

recognizing the Medicare payment would so dramatically change what is counted as shortfall is just ludicrous in many respects.

My sense of the court decision is it's a very legalistic one, which is that the language wasn't there in the law, and therefore, I cannot, in some respects, legislate sort of for you, Congress.

Having said that, what worries me about this a bit is what's going to be the distribution across hospitals because every hospital is not uniform in terms of composition of their patients, Medicaid versus Medicare, or these -- I mean, to talk about private is a little bit of a misnomer because it's a very special group of private patients that are affecting this distribution.

And that is actually what leads me more to be thinking about Recommendation 1, which is that we do count the Medicare patients and not just the Medicaid-onlies.

Part of what makes me sort of focus on that is I feel like that in some ways, there is a Medicaid underpayment for Medicare patients when they're not paying the deductible or they're only paying a portion of the deductible. I don't have a sense of magnitudes here. I

mean, how important sort of is that in terms of calculating this shortfall?

I feel like I'm at a disadvantage not knowing what the cross-hospital impacts are going to be. Who is going to lose how much if we were to implement these different recommendations, and what are the characteristics of those groups of people that are losing different amounts of money from having a different recommendation?

Again, I feel like there's variation across hospitals in sort of their patient mix and therefore their impact from making one or another of the recommendations.

VICE CHAIR LAMPKIN: Thanks, Bill.

So when you're leaning towards Option 1 and you specifically called out Medicare and the Medicare shortfall aspect of that, you don't have the concern about the treatment of the third party, the private payer?

COMMISSIONER SCANLON: I do. I do have a concern, but I feel like that it's such a special case, I'm not sure what we could do about it unless we were to say -- I'm thinking about is there a rationale to say we should only count Medicare and Medicaid patients in this process.

VICE CHAIR LAMPKIN: And that would be the Option

3, though, would be to distinguish between the type of third-party payer in some way.

COMMISSIONER SCANLON: Well, I mean, as part of that, totally exclude one type of payer, that I could deal with.

VICE CHAIR LAMPKIN: Oh, sure. Thank you.

Chuck and then Melanie.

COMMISSIONER MILLIGAN: Great job, Rob. We're never quitting you.

[Laughter.]

COMMISSIONER MILLIGAN: I think where I want to start is that we need to do something, okay? I think all of these are better than the status quo.

I do find myself aligned more to Option 2 for a number of reasons. I do think apart from the reasons that you've articulated here, to me one of the elements that factors in is just the fact that so many Medicaid-onlies are aging into dual eligible status with just demographics. And I actually need to think this through a little bit, but I would hate to have a framework where this is getting rebased in significant ways or redistributed in significant ways based on a lot of those demographic changes as people

become duals.

So I think to me, part of what would be helpful is just -- and it varies, I think, in some important ways across states. It's just in terms of sort of demographic factors about proportion of near-senior boomers aging into Medicare. I think you sort of see in the upper Midwest more of that kind of proportionately happening.

I know that I'm sort of further complicating this, but trying to tease out the Medicare implications in light of the demographic age-wave implications, I think is -- and the goal of some level of administrative simplification, I think we need to sort of think that piece through.

One of the comments I want to make is I agree with Alan about Medicaid often isn't the rate setter. Medicaid can sort of influence that by payment policies, lesser of and other things, but I do think that we need to pull out of the DSH calculations, the effects of the court decision, about rewarding hospitals that have high private pay because the other end of that spectrum are safety-net hospitals that don't have access to private pay, a lot of county hospitals and more teaching hospitals and others

that are losing in that calculation. That I think to me the policy objective needs to be DSH funds should go to true safety-net hospitals serving a lot of individuals with uncompensated care.

So I aligned more toward 2, but I do want to have a better understanding kind of in the run-up to April about just implications of Medicare from a demographic perspective.

Thanks.

VICE CHAIR LAMPKIN: Thank you.

Melanie and then Fred.

COMMISSIONER BELLA: I'm voting for a solid 3 -- not voting. I'm lobbying you all.

I guess a couple things. One is if we're worried about protecting access, then the sentence that worried Alan, the same sentence worries me about the impact of hospitals' willingness to serve duals.

If we don't know how hospitals are going to behave, we're speculating that private pay -- there's incentive to turn away private pay, and there's incentives to turn away duals. And so I think we would have to weight those equally. If we're going to be worried about one, we

should be worried about the other.

I guess the other point is when I think about -- I don't disagree. I'm respectful of the concept of Medicaid as the payer of last resort and Medicaid it not the rate setter, but when it comes to duals, we have made these two programs so intertwined and so messed up that it's really hard for me to say that you have to look at Medicare's rate setting and at the absence of Medicaid because Medicaid is the payer of first resort for many services for this population, and the impact of the Medicare payment or on Medicaid-funded services, for which it is the payer of first resort, there is a relationship there.

So I just think that it's harder to say that -- it's harder for me to disconnect those two than it is for me to disconnect Medicare and commercial payment rates, for example, and so that rationale isn't as persuasive for me.

I guess it's somewhat of a copout, I guess, to pick Option 3 because then we're sort of coddling to both groups, but if we think there's a legitimate access problem, I think we've got to look at that for both sets of populations that we're talking about here, and so the safer

way or the more gradual way would in my mind be to do Option 3.

COMMISSIONER CERISE: Okay. So, Melanie, you've given me something to think about.

First off, I just agree with everyone else. We're in an absurd situation right now that deserves to be addressed.

You do end up, to Chuck's point -- and DSH is a zero-sum game once you get to the state level, and so the current ruling ends up rewarding hospitals that have a higher insured rate at the expense of hospitals with a higher uninsured rate. Rob pointed that out in his piece, and I thought it was a significant point.

This potential redistribution -- and here's my disclaimer. It's real redistribution, and it's happening. And I'm on the short end of it at my place to a significant degree. So that's my sort of personal disclaimer that I have an interest, at least my facility does, because it's getting impacted by this redistribution, which is a real redistribution where you're paying some hospitals twice, whether it's Medicare or a private insurer, and then coming back with a Medicaid payment at the expense because it is

at the expense, and money is getting shifted. What happens in the public's hospital sector is that that ends up being the taxpayers that have to fill that gap on the public side while Medicaid becomes the second payer for the group of hospitals that end up getting paid twice.

I was migrating to 2 for simplicity and the reasons Alan pointed out, would not be opposed to looking more -- discriminating more to see if there's something there with this, with the Medicare piece.

I don't want too complicated. You lose track of the fact that you're double-paying here, and that needs to be addressed.

VICE CHAIR LAMPKIN: Toby.

COMMISSIONER DOUGLAS: I have a question back to the policy that was in place in 2010. Do we have any evidence that there were these disincentives that were going on, on that policy?

MR. NELB: Sure. So the policy within 2010, DSH audit rules started getting enforced in 2011, and that was the case where these hospitals then started -- some of these Children's Hospitals, for example, had their DSH payments recouped.

In terms of timing, it's hard to know, and I think, speaking with some of the hospital associations, no hospital is purposely not enrolling someone in care.

They just highlighted this issue as sort of a perverse incentive, but from the provider level, the low-birth-weight babies are pretty much automatically enrolled.

The question, I guess, comes up with patients who want to get Medicaid for post-hospitalization services, so maybe some HCBS services that aren't covered in their private plan. Hospitals are taking a role of helping enroll someone while they're in the hospital so they can access this care after they're discharged. In theory, it's a potential barrier, but I don't think we have much data to say that that actually has come up as an issue.

And then for timing-wise, also, because the 2011 audit wasn't actually completed for several years after that, I think when they were doing the audits, they realized that different states were enforcing this policy in different ways.

COMMISSIONER DOUGLAS: Thanks.

VICE CHAIR LAMPKIN: Rob, I have a --

COMMISSIONER SCANLON: Can I ask a question?

VICE CHAIR LAMPKIN: Sure.

COMMISSIONER SCANLON: If a hospital is helping you enroll in Medicaid for post-hospital care, it will not affect any of these calculations, will it?

MR. NELB: It could potentially.

So the trick is that in the statute, it says that anyone who is Medicaid-eligible is supposed to be counted in the calculation. But when we speak to some of the auditors who are actually doing this work on the ground, in a practical matter, the hospital doesn't know if the person is eligible or not until they're actually enrolled. So when the auditors go through, they will look at how many claims are for people that are flagged as being -- have a Medicaid card or something for that service.

So if they end up being enrolled, then in the hospital system, they get tracked as being Medicaid-eligible, and therefore, their costs and payments are calculated in the calculation according to CMS's 2010 policy.

VICE CHAIR LAMPKIN: Thanks.

I have a question about the comment in the materials about the states who have been capped and are not

able to spend all of their allotment because they're capped and the court ruling's effect on essentially allowing them to tap into more of their allotment. So options would decrease that to some extent.

I note you said you couldn't quantify that by option, but is there an ability to say that more of that is related to the Medicare side versus the private payer side or in any way to even have a sense of where the bulk of that is?

MR. NELB: Sure. So, yeah, as you mentioned, there is about six states that accounted for most of the $1.2 billion unspent DSH funds. One of those states is New Hampshire, and from early data that we have from New Hampshire is that after they applied this new policy, their DSH payments increased by 50 percent.

That's applying the new policy under the court ruling. It's less about whether it comes from Medicare or Medicaid, but just the fact that -- Medicaid or private insurance, but just the fact that they are now paying for the cost that those third-party payers paid for. That's the piece that's increasing the amount that the state can pay.

As I showed in that Medicare example, the hospital can get now 10 times as much for the same patient, so that's the piece about why a state like New Hampshire can spend more money under the court ruling.

CHAIR THOMPSON: Chuck and then Penny. I'm sorry. Sheldon and then Penny.

COMMISSIONER RETCHIN: Thanks, Chuck.

Can I just ask you -- I'm still kind of -- I'm with you guys.

[Laughter.]

COMMISSIONER RETCHIN: There's a comment here about King's Daughters. First of all, I was really unaware that those with private insurance are automatically eligible for Medicaid, regardless of their insurance or personal income type. Is that true in a NICU? Is that true?

MR. NELB: So I'm not the eligibility expert, but they are deemed eligible for SSI. I believe that there are sometimes some income rules for SSI, so maybe not all will be counted.

But if you are eligible for SSI, then you're automatic --

COMMISSIONER RETCHIN: Oh, okay. So there may be some qualification.

COMMISSIONER GORDON: Yeah. In their situation, if an individual is in the hospital, a child is in a hospital for an extended period of time, then the parents' income is not calculated.

COMMISSIONER RETCHIN: So it's related to just the length of time. So if Jeff Bezos' divorce goes through and gets remarked, then that kid would have -- it's completely, to use the word "divorced" from income status.

So when you made the comment that children at King's Daughters was nine-fold difference on average, that's because of this unusual population. That population generates such high costs in intensive -- in a neonatal intensive care unit, right?

MR. NELB: Yeah. So the nine times was the cost per patient. In that example, there were 2,000 patients, Medicaid with private insurance --

COMMISSIONER RETCHIN: Yeah.

MR. NELB: -- and then about 100,000 that were the Medicaid-only children. So just a few on that private insurance side, but they accounted for such a high cost

because a lot of them were these high-cost patients.

CHAIR THOMPSON: I wanted to ask a question, and maybe this will help us think a little bit about how we construct our recommendation because I'm totally with everybody here, which is the current situation just needs to be fixed.

I don't have strong feelings about which of the options are the better ones. Admittedly, I kind of came in with an idea that we were just returning to status quo, and status quo was 2010.

But that's what I want to ask about, which is so we're talking here about amending legislative language. If we amend the legislative language to basically fix the situation back to what it was before, then that would leave -- one possibility would be to leave the decision about how to calculate this in the hands of the administering agency because that's what was happening before.

Before, it was the agency who issued the guidance about what was counted or not counted, correct?

MR. NELB: Yeah. I think another option would be to let CMS decide.

I think CMS felt the way that the statute was

constructed before that they didn't have an option about whether to include the duals or not or the Medicaid patients with private coverage. In changing the statute, it could better clarify that maybe CMS could make a decision about that.

CHAIR THOMPSON: Okay. So then I take back that idea, which was simply to say one option would be to discuss the options and advantages and disadvantages got handed to the agency, but if we believed that the fix to the language would actually tie the agency's hands to a particular option, then that would not be something that we could consider.

MR. NELB: Well, I guess I wanted to say that you could construct the language in a way that would give CMS more of an option, an option to do Option 2, which CMS doesn't feel like -- under the existing statute, they didn't feel like they had that option, so just reverting to the 2010 policy, it's actually adding this piece about third-party payment. It doesn't give CMS as broad a flexibility as you might want to if you want to allow all these possible scenarios.

CHAIR THOMPSON: Thank you.

VICE CHAIR LAMPKIN: Okay. Brian. And then maybe we'll ask the public if they have any feedback before we determine next steps.

COMMISSIONER BURWELL: So I'm attracted to Option 2 by administrative simplicity, but I also align myself with Melanie who thinks that we should count Medicare shortfall as well.

But I'm wondering if we go with Option 2 and there's Medicaid shortfall associated with copayments and deductibles for duals, are there other mechanisms for hospitals to recover those costs through supplemental payments? I mean, I'm going crazy here.

MR. NELB: Yeah. So let's see. A state could change its “lower of” policy for hospitals.

In Medicare, hospitals do receive some payment for non-reimbursable bad debt, but the portion for the duals is not part of that. I can think about that, but DSH is one way -- I guess the sort of paid for now, but we'll think about whether there's other ways that it could be paid for.

VICE CHAIR LAMPKIN: Toby.

COMMISSIONER DOUGLAS: Maybe I'm making it too

complicated, but could we recommend Option 2 but also give the authority for CMS to evaluate since we don't even know if the perverse incentives would occur and if after that they would have the flexibility to make changes to exclude different types of third-party payments if there were clear indications after the evaluation.

CHAIR THOMPSON: I would just jump in to say we could construct a recommendation that basically says we need to fix the legislative language so what is happening now is not happening, and then we could go on to say we discuss different options for what's counted or not counted. We could describe the Commission's consensus without necessarily needing to take votes. So we could be providing advice to the Congress about the fixes with the idea about focusing attention on it needs to be fixed, as the primary message, with how you fix it. There was a view of the Commission that mostly people liked this, but other people made these points.

So we have those options, which might be the easier way to handle the uncertainties if the Commission believes that it is too split among the various options, that it might want to ensure that it makes the bigger point

that the current situation cannot stand.

VICE CHAIR LAMPKIN: Thanks.

Alan.

COMMISSIONER WEIL: I just want to ask a question. Melanie, your sense of the risk resonates, but I'm trying to understand how real this is. Maybe it's no more or less real than the Children's example.

Can a hospital take Medicare and not take duals? That's what it sounds -- I'm just trying to understand sort of what's the dynamic whereby not allowing the duals in the calculation leads to behavioral change by the hospital.

I don't mean to put you on the spot. I'm just really trying to understand.

COMMISSIONER BELLA: I think it's that it just becomes an access issue in terms of who they're prioritizing, how quickly they're getting folks in, whether beds are available.

I mean, I think it's the same thing we've seen when you see a correlation, a relationship between primary care payment rates and participation in serving these populations. So I think that you do see a play-out in more covert ways than overt ways, but I think that it's been

measured in the past. I think some might take issue with that, but I think there is something there. And some states, it's worse than others.

I know we can't talk about Medicare here, but if we're not going to address this, then maybe we send a message that MACPAC could take a look at some payment policies and the relationship between Medicaid and Medicare, and if we make a change to what's included in Medicaid shortfall with regard to Medicare payments, then perhaps MedPAC might take a look at the impact of that, as Medicare as the primary payer on this population.

VICE CHAIR LAMPKIN: Let's see if any folks in the audience have comments that they'd like to make about the conversation.

PUBLIC COMMENT

* MS. LOVEJOY: Hi. I'm Shannon Lovejoy with the Children's Hospital Association.

First, we really wanted to thank the MACPAC staff for really digging down into this issue. We were able to connect staff with Children's Hospitals, and we are appreciative that folks took the time to kind of hear about how this has played out for many of the hospitals and bring

that discussion to the Commission because we do think this got more into the weeds on what is a very challenging topic.

I do want to just emphasize some of the impact on Children's Hospitals. Children's Hospitals are safety-net providers. Over half of the patients treated at these hospitals are on Medicaid, and with the role of supplemental payments, supplemental payments in general, but especially DSH are important to Children's Hospitals in addressing the Medicaid shortfall component. This is what helps allow them to provide the best care to patients as well as maintain critical training and research programs that impact pediatrics in particular.

The CMS policy has had a very significant and negative impact on Children's Hospitals in large part because of the role of how private insurance and Medicaid works together for kids. It is one of the few populations where you really get this different kind of coverage situation because these kids tend to have extensive and expensive health care needs, and Children's Hospitals happen to have the capacity to treat these patients in general.

So I think that's part of the reason why the magnitude has been felt more on the Children's Hospital side for some of these patients.

In terms of the enrollment, Children's Hospitals do work very hard to enroll kids into the Medicaid program and identify who is Medicaid eligible. A lot of times, these families are trying to figure out how to best care for their kids, and they have long and extensive hospital stays. A lot of times, this really isn't about -- Medicaid isn't there for the hospital payment, but these kids really do need the services and supports back in the community. And to help improve their overall care, the hospital is really trying to connect them with the resources that they will need, so when they are discharged from the hospital, they have as successful of a recovery as possible or to maintain a high level of services.

I definitely gather from the direction of the Commission that you are looking to issue a recommendation. We are still urging that you refrain from issuing a recommendation at this point. As you know, there is ongoing litigation, and we did want to point out that oral arguments are scheduled for the week in April when MACPAC

is meeting again. So that is our ask at this time.

But we do want to thank you again for digging down into the weeds for a very difficult issue, and thank you for the opportunity to provide comments.

VICE CHAIR LAMPKIN: Any others?

[No response.]

VICE CHAIR LAMPKIN: Thank you for those comments.

Any other Commissioners have questions or comments before as we give Rob some guidance about next steps for a while? It sounded like we had a couple of requests for additional information, but we might have been narrowing the options down to take maybe Option 1 off and focus more on Options 2 or 3. But then towards the end, it sounded like there might be an Option 4 of "Fix it. We're not going to specify how, but we want to say this needs to get fixed."

CHAIR THOMPSON: Yeah. I mean, my view is much more of we need to rectify the situation with a discussion about how it could be addressed, if we don't have a strong feeling why it should land in one direction or another, and I guess that's the question as to whether or not there's

any additional information that Commissioners would have.

Or we could even just bring it back up at the next meeting. If Rob has some additional information, we could spend a little bit more time on it. We could see if the Commission starts to gravitate through conversation to one of the options versus the others, and if so, that becomes part of the recommendation. And if not, that's something that we can just put in a discussion point about that "how" answer.

EXECUTIVE DIRECTOR SCHWARTZ: So I have a question, just from a very practical perspective. Bill raised a question about effects on different types of hospitals, but I guess I would like to know, is there any other specific information that people need, other than time to sit with it and think about it?

I mean, it's always the case that the more time you spend on it, your views on it start to coalesce. Is there anything else that people think that we can conjure up that would be useful?

CHAIR THOMPSON: I do have one suggestion, Rob. Shannon's point, commentary made me think about this. There's three periods of time here, right? There's today,

which we think the situation is not good. There's the situation that followed the 2010 guidance and what was happening then, but then there was a situation that was pre-2010 guidance and what was happening then. So is there anything to be learned from those three time periods?

MR. NELB: I could try to look. The challenge is that 2010 guidance is through the DSH audits, so that's the source of data that we have to know about distribution of DSH payments.

EXECUTIVE DIRECTOR SCHWARTZ: Right. There's a story about what happened before, but not data.

MR. NELB: Yeah. But I'll see if I can find anything.

CHAIR THOMPSON: Because it seems to me that the conversation is largely around where do we want the incentives to be.

We want the policy incentives to be that everybody gets all available coverage. We want private coverage from people who have access to private coverage. We want Medicaid coverage from people who are eligible for Medicaid, and we want Medicare coverage when people are eligible for Medicare.

COMMISSIONER GORTON: So, Anne, to answer your question, I think Stacey asked this, and Rob helped us as little. But if there's any more light you can shed on the relative weights of which things are a big deal -- I mean, the King's Daughter example is clearly -- but that's the Children's Hospital case.

So, to Bill's point, in the grand scheme of money moving around, obviously the Children's Hospital money is important to the Children's Hospitals, and obviously, in the Texas scenario, Fred has given us firsthand feedback that moving hospital to the Texas Children's Hospitals has negatively impacted the public hospitals.

If we can just get any kind of illumination on what the puts and takes are, that would be helpful to me. So that's just one -- any more quantitative stuff -- I guess I came away with reading the material -- well, I don't read the -- I came away with listening to the materials for this meeting with some sense that the recommendations were awash, and I guess part of it is the staff are years-deep into the data.

If it's really awash, fine; then it's awash. And maybe that's what we need to be able to say to the

decision-makers.

If there's a signal in there in all of this noise, if you could highlight that for us, that would be useful.

And then the last piece is, while I'm sympathetic to the idea that we say this is a mess and somebody should fix it, if we can't come up with a recommendation to what the right answer is, how do we expect people who are less in the weeds on Medicaid?

It seems to me that we sort of have an obligation to try and come up with the best fix. We may not say it's a slam-dunk, right? I think one of our recent recommendations was sort of like, well, some people wanted -- it was probably DSH -- that the way to calculate DSH, right? Some people thought this way was good; some people thought that way was good. And the majority of people -- we may have to do something like that, but I think we should put our money on the table and make a bet.

VICE CHAIR LAMPKIN: Just for the record, I agree with Kit on that latter point, rather than just a fix recommendation, personally.

Bill.

COMMISSIONER SCANLON: I'm actually a little hesitant to sort of pursue my request for information because I think it gets complicated because I am not talking about type of hospital in terms of Children's versus sort of community hospital that serves a broad population.

I'm thinking a lot about the financial status of these hospitals because there is this reality that Medicare may be paying -- and there's hospitals today that are getting sort of 80 percent of cost or maybe even a little less, but they're also, because of what they're doing on the private side, generating huge surpluses. We're talking about they're sitting -- I know of one. I can tell you that over three years got $1.2 billion in surplus.

I don't want something to advantage them, but there's another part of this equation, which is how the state chooses to distribute the DSH dollar. What we're talking about largely is changing the cap as opposed to changing that distribution, and so there's this question of what should the concern about the cap be.

VICE CHAIR LAMPKIN: Well, but then many states have their distribution based on levels of uncompensated

care.

COMMISSIONER SCANLON: And the key in what you just said is "many." Yeah, so --

VICE CHAIR LAMPKIN: Chuck.

COMMISSIONER MILLIGAN: I just had a thought listening to this.

So, Rob, to me, I think it would be helpful in April also to just kind of estimate a timeline. If we were to make a recommendation, what we're talking about is something statutory. It would have to then pass.

That would then presumably lead into maybe a rulemaking process or not, depending, and then that would affect a DSH year of acts.

So, to me, part of the options and the administrative changes embedded in the options and what year it may or may not take effect, like reporting pieces of that, I think to me would be relevant as an impact because the more that time passes with this court decision influencing the environment and how long that kind of settles before it were to change, it seems like it varies by some of these options because of the reporting cycle and the statutory regulatory pieces of it.

I do think that that timing piece is a relevant factor to me in terms of whether or not -- like the environment kind of resettles in a new place that is more or less disrupted by what we intend to do.

VICE CHAIR LAMPKIN: So let me validate one thing that I think I'm hearing. That there's a general consensus that the disincentive produced by Option 1 or the 2010 mechanism with the private payers is undesirable. I'm not hearing, I don't think, a lot of appetite for Option 1, partly because of that.

So is a next step for Rob --

CHAIR THOMPSON: I don't know. I mean, I guess I'm wondering. Things existed from the 2010 guidance on, and I don't know that we have any actual evidence as that policy was in progress that we had actual results of the kind that we're concerned about. I think that's an argument to still consider that as an option, again, in the sense of if we haven't settled as a group in one place, I personally would not want to see us take Option 1 off the table for further thinking, if we're doing further thinking.

VICE CHAIR LAMPKIN: Okay, thanks.

CHAIR THOMPSON: Although narrowing options is always nice.

VICE CHAIR LAMPKIN: Right. I was trying to narrow it down, but maybe that's premature.

So do you feel like you have gotten the kind of feedback you need to come back for us in April?

MR. NELB: Yeah. I'll take this back. We've got a way to present it. We do have a little bit of information about Medicare payments to different hospitals and Medicare DSH payments and how that affects different types of hospitals, so I'll see what there is there, and that will kind of inform this discussion.

EXECUTIVE DIRECTOR SCHWARTZ: I personally have a concern. I mean, I have a lot of confidence in Rob. We spend a lot of time going over these things. I am not so confident that he is going to find a magic answer for you, and this applies a little bit to the discussion we had about the rebate cap earlier in the morning.

If you are not settled where you are, I'm a little concerned about rushing to judgment at the next meeting to get to something in the June report just because the June report is a thing we have to do.

The June report literally could be a piece of notebook paper that says, "Here's your report, MACPAC." Obviously, we do not want to do that. But if you're really not ready, you can make a recommendation at the September meeting, and we could publish subsequent to that.

So I guess a better sense from you all about narrowing the choices would be helpful. For Rob to come back at the next meeting with a tiny bit more information and then you feel a sense of obligation to hurry up and make a decision at that meeting because we've got to get this done concerns me.

I do think it's also -- I mean, to Penny's point, that if you don't think there's any way that everyone can come to a decision and you do think that doing something is better than doing nothing, then doing Option 1 while having a rich discussion about the issues around 2 or 3 is fine. But then that leaves open the question of who else is going to figure it out.

CHAIR THOMPSON: So I'll just jump in to say that decision also does not get better with more time in September either.

I mean, I think that with the rebate cap, I think

we had -- I think we got to a great place with that conversation. We decided what we were looking for. I think people will be ready after that discussion in a way that they weren't at the beginning of that discussion to resolve it.

I think the same thing is true here. We do have various options. That if we can't settle on a particular option, then I think we can still outline the options, discuss them, talk about fixing them. That is not as good as settling on one, but if we can't settle on one, we haven't settled on one.

I think it's also true to say that there may be a number of Commissioners that feel like -- pick one. If there's not a lot of evidence to say one is superior to another, then all are equally viable, so that's another way to think about presenting them, not that we can't decide, but there isn't much to distinguish them from a policy perspective.

So I do think that as in other cases, having had the opportunity to have the conversation -- and as you mentioned earlier, Anne, sort of settle on it, I think actually does put us in a position to make a decision at

the next meeting. And I think doing that in a timely way also makes sure that we don't forget what we talked about, which sometimes we also have a danger of doing.

COMMISSIONER RETCHIN: I think listening I could be convinced about the -- I think if we just -- if we had more time, we could just tell the foreman to take the jury back into the room, we would convince each other.

COMMISSIONER BELLA: I guess it's hard for me to believe that they're all the same and they all have the same outcome.

The problem is we're making assumptions about people's behavior. So I think at this point, if there's not data to support it, we either believe the hypothesis that it's going to be a deterrent for duals and private pay and we pick No. 3 or we believe it's not a deterrent for duals and private pay and we pick No. 1.

So it seems like we really just have to make an assumption about how we think hospitals are going to behave, and if we want to anticipate that, then we try to insulate both groups that could be affected, which would be Option 3. Or we decide if we don't think we have enough information to know, if that's going to be the case -- we

didn't see that after 2010. So we go with Option 1.

COMMISSIONER CERISE: My concern is that we don't act.

CHAIR THOMPSON: Oh, I don't think there is a chance of that. I think we will come back --

COMMISSIONER CERISE: And we don't timely --

CHAIR THOMPSON: -- and this will be on the agenda next time. We will discuss the detail of the recommendation and whether or not we want to orient our recommendation towards a general fix or a fix in a particular way, and I think that we'll have another discussion about of these methods, is there something that is in our belief superior to the others and one that we want to vote on, and that's doubled up.

VICE CHAIR LAMPKIN: Okay. Break for lunch?

CHAIR THOMPSON: Okay. We'll go ahead and take a break, and then we will be reconvening at one o'clock with Puerto Rico.

Thanks, Rob.

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

AFTERNOON SESSION

[1:03 p.m.]

CHAIR THOMPSON: Okay. Why don't we go ahead and get started again and pick up this afternoon with our first session. Kacey and Chris are going to walk us through some data relating to Puerto Rico.

MEDICAID IN PUERTO RICO: FINANCING AND SPENDING DATA ANALYSIS AND PROJECTIONS

* MS. BUDERI: Yes. Okay. So today, we're going to continue our discussion of Medicaid in Puerto Rico. The work we've done on this issue recently has been in response to a request from the House Committee on Appropriations, and you will recall at previous meetings in October and December 2018, we discussed the issues facing Puerto Rico's Medicaid program, the most sensitive of which is the major reductions in federal funds beginning in FY 2020 referred to sometimes as the "Medicaid fiscal cliff."

And Commissioners have expressed interest in looking more in depth into some of the data to get a better picture of Medicaid financing and spending in Puerto Rico. So today, we're going to be providing you with some new analysis we've done on Puerto Rico's Medicaid enrollment

and spending and the implications of that fiscal cliff.

So I'll walk you through it, and then Chris, who is responsible for much of the data analysis work here -- Chris and I can answer any questions that you have.

So before I start, I just want to note that the other four territories are also facing a Medicaid fiscal cliff, but this presentation only focuses on Puerto Rico. And the reason for that is we don't have the data that we would need to do a similar analysis for any of the other territories.

So I'm going to start by going over the exact language from the congressional request. I'll recap on some background information on Puerto Rico and the structure of its Medicaid program, including its financing arrangement, and then I'll get into our analysis.

I'll describe Puerto Rico's Medicaid spending and how it compares to the 50 states and the District of Columbia when adjusted for differences in benefits and enrollment mix.

I'll then discuss some of the challenges Puerto Rico is facing in FY 2020 and over the next couple of years when the reduction in federal Medicaid funds will occur.

I'll provide some different spending projections under different financing scenarios, including scenarios where Congress does or does not provide additional federal funds in FY 2020.

And then I'll describe some of the choices regarding benefits and eligibility that will face program administrators under different financing scenarios.

So starting with the congressional request, in the report accompanying the FY 2019 Labor, Health and Human Services, and Education funding bill, the House Committee on Appropriations requested that MACPAC examine possible options for ensuring long-term sustainable access to care for Medicaid beneficiaries in Puerto Rico. This request has no specific due date, and it does not require recommendations.

So, as we've noted in prior meetings, Puerto Rico is the oldest and most populous U.S. territory, with a population of slightly over 3 million people. It has a high poverty rate. It was over 40 percent in 2017, and it has a high portion of residents covered by Medicaid.

In 2017, Medicaid covered over 1.5 million people or almost half its population.

In general, Puerto Rico is considered a state for the purpose of Medicaid, unless otherwise indicated, and it's subject to most federal requirements, and has many of the same roles, responsibilities, and administrative structures as states.

However, there are several differences in how Puerto Rico's Medicaid program operates. For example, with respect to eligibility, they use a local poverty level rather than the federal poverty level. Additionally, they don't cover all of the Medicaid mandatory benefits, including long-term services and supports or non-emergency medical transportation. And then the most significant difference is with regard to the financing structure.

So the financing structure for Puerto Rico's Medicaid program differs in two fundamental ways from the states. First, while Puerto Rico has an FMAP like the states, it's set in statute at 55 percent. If it were determined that using the same formula used for states, which is based on per capita income, it would be the maximum allowable rate of 83 percent.

Puerto Rico does receive the expansion state FMAP for adults without dependent children that states were

eligible to receive for expansions enacted prior to the ACA, which is 93 percent in calendar year 2019.

So Puerto Rico draws down federal dollars at this matching rate, but unlike the states, it can only do so up to an annual cap. And this cap is sometimes referred to as the "1108 cap." It was set in 1968, and it grows with a medical component of the Consumer Price Index. But it's not clear what factors Congress considered when they were initially setting that cap, and the amount provided by the cap has historically been insufficient to cover the federal share of Puerto Rico's Medicaid costs.

So these two financing pieces, the statutory FMAP and the cap, have led to a substantially lower level of federal financing than would otherwise be the case, and at times, the federal contribution has dropped to below 20 percent of total spending. And so to make up for this, Puerto Rico has historically had to take on a much greater share of the program than would be expected of a state or that the 55 percent FMAP would normally require.

So, in recent years, Congress has provided additional federal funds on a temporary basis to help make up for the federal funding shortfall. The ACA provided

$6.3 billion in additional federal Medicaid funds to Puerto Rico, and the bulk of this was provided via Section 2005, which is available to be drawn down between July 2011 and September 2019. Section 1323 provided additional funds, which are available through December 2019.

And Puerto Rico went through these funds faster than anticipated. When they appeared like they were about to run out, Congress provided an additional $295.9 million through the Consolidated Appropriations Act of 2017, which was added to the Section 2005 funds. And then when that started to run out and then when Hurricane Maria struck in, I think, September 2017, Congress provided an additional allotment through the Bipartisan Budget Act of 2018, and it totaled $4.8 billion available at a 100 percent matching rate.

And the BBA funds came in two different parts. The first $3.6 billion was guaranteed. Another 1.2 was conditional on Puerto Rico meeting milestones related to T-MSIS reporting and establishment of a Medicaid fraud control unit, and they have achieved the targets for doing those things. So they will get that conditional $1.2 billion allotment.

So this slide is to give you a sense of Puerto Rico's Medicaid spending and the sources of funds. This graph shows actual Medicaid spending in Puerto Rico for fiscal years 2011 through 2017 and projected spending for FY 2018 through 2019.

In all years, federal spending exceeded or is projected to exceed the annual cap, which is shown in dark blue at the bottom. Up until 2017, additional federal spending reflects use of the additional funds under the ACA as well as a small amount of spending not subject to the cap.

In FY 2018, it reflects some use of funding under the ACA as well as under the BBA, and then in FY 2019, the cap amount is shown for illustrative purposes. But Puerto Rico is actually using almost entirely those BBA funds for FY 2019 because of the 100 percent matching rate.

You can see here the degree to which Puerto Rico's Medicaid program has been reliant on these additional funds for the federal share of the program, and over time, you can see that spending grows. And then especially in FY 2018 and 2019, the share of spending that is federal has grown due to the 100 percent matching rate

on the BBA funds. However, despite this, Puerto Rico is still spending much less per enrollee than states are, which is part of the data that we'll show you.

So to provide better information and context about Puerto Rico's Medicaid spending, we did this analysis to compare Puerto Rico spending to that in the 50 states and the District of Columbia.

To do this, we went through a few different steps. We used data provided to us by the Puerto Rico Health Insurance Administration, or ASES, and their actuarial contractor, Milliman. We calculated projected Medicaid benefit spending per full-year-equivalent enrollee. We calculated the same thing for the 50 states and the District of Columbia using MSIS data, which we trended to FY 2020 using CMS Office of the Actuary trends.

Because Puerto Rico does not provide LTSS, long-term services and supports, we excluded state spending on LTSS, and then we re-weighted each state's enrollment across eligibility groups to match the enrollment mix in Puerto Rico.

So this is a box and stem plot that shows you the distribution here. This figure shows the projected FY 2020

distribution of benefit spending per full-year-equivalent enrollee in the 50 states plus D.C., and it shows the same for Puerto Rico.

So the top of this stem right here shows the state with the highest per-full-year-equivalent benefit spending. The bottom will show the state with the lowest. This middle line is the median state, and then the top of this box and the bottom of this box are the third and the first quartiles. So you can see that Puerto Rico is below the minimum state for both total spending and federal spending.

You can actually see that Puerto Rico's total spending is below the minimum state's federal spending. So even if the federal government took on 100 percent of Puerto Rico's Medicaid spending, it would still be spending less per-full-year-equivalent enrollee in Puerto Rico than in any state.

So shifting gears a little bit, going into FY 2020, Puerto Rico is facing challenges from both the federal and the commonwealth sides, which could affect its ability to provide services to enrollees, and these include the so-called "Medicaid fiscal cliff," but they also

include mandatory spending reduction targets imposed by the Puerto Rico Oversight and Management Board, sometimes referred to as the "Fiscal Control Board."

So the Financial Oversight and Management Board is a board set up under the PROMESA legislation, which has discretion over the territory's budget and financial plans and the power to force debt restructuring with bondholders and other creditors, and as part of the fiscal plan that they certified for Puerto Rico, they are requiring Puerto Rico to reduce Medicaid spending. These reductions must amount to $826 million annually by FY 2023.

The board and the Puerto Rico government are hoping to achieve these savings through reforms to the managed care system, which you heard a little bit about at the December meeting from our panelists.

For example, they anticipate that changes to the contracts could achieve $478 million in savings off the FY 2020 baseline and that additional savings could come from improvements to program integrity capabilities, prescription drug cost controls, and standardization of provider fee schedules.

However, there has been a lot of concern among

stakeholders that these planned reforms will not yield the level of savings that are required, and that Puerto Rico will need to do some benefit and eligibility reductions in order to achieve those savings.

There's some uncertainty around the requirements themselves. It's not clear how the reductions will be enforced or how they'll be affected if additional federal Medicaid funds are provided, but it's an important piece of context as we think about the challenges that Puerto Rico is facing.

So on the federal financing side, as I mentioned, we have this upcoming fiscal cliff. Puerto Rico has had sufficient federal Medicaid funding since 2011 when ACA funds became available, and it is reporting that it will continue to have enough through fiscal year 2019. However, it's expecting to face a funding shortfall in FY 2020 and again in FY 2021.

So going into FY 2020, Puerto Rico will have approximately $586 million in Section 1323 funds provided by the ACA, available through December 2019. In addition, they'll have that $374 million Section 1108 allotment, which is available for the full fiscal year.

Puerto Rico's spending projections assume that it will be permitted to use the ACA Section 1323 funding prior to its regular 1108 allotment in FY 2020. So all of the projections that I'm going to discuss going forward also operate under that assumption, but we've received some mixed messages about the order that territories can access these supplemental versus normal annual cap funds. So that could affect the projections.

So, as of right now, Puerto Rico, as I said, is expecting these funding sources to last through FY 2019 and up until sometime in March 2020, and after that, there is going to be a federal funding shortfall. There will be no more federal dollars available for Medicaid, and the federal funding shortfall for the fiscal year will be about $1 billion.

Though Puerto Rico will again have access to its annual 1108 allotment in October 2020, the beginning of FY 2021, it expects these funds to only last until sometime in December. And just as an additional note for context, Puerto Rico is not expecting to use all of the funds available to it by the expiration dates. So up to $875 million in ACA, BBA, and 1108 funding combined could expire

unspent.

Without additional federal funds in FY 2020, Puerto Rico will either need to increase its own Medicaid spending by about $1 billion to make up for the gap in federal funds or it will need to reduce spending by the same amount.

In the period before 2011, when ACA funds became available, Puerto Rico was historically able to use territory-only funds to make up for the shortfall in federal funding, but due to a variety of factors, it's unlikely that Puerto Rico could do this in FY 2020. And it's likely that they would have to reduce spending.

If Congress chose to address the funding shortfall by providing Puerto Rico with additional federal Medicaid funds, it would have to make choices for how to structure them, including the amount, the matching rate, and the time period available.

So there are a variety of different scenarios that could take place here, and I'll walk you through a few of them.

In terms of this first bar right here, this first bar right here outlined in red shows spending assuming that

Congress has provided sufficient federal funds to fully match all projected spending in FY 2020 at the 55 percent FMAP available under current law.

It shows that Congress would need to appropriate at least $1.01 billion more for the fiscal year, and the remainder would be covered through the normal 1108 cap, ACA Section 1323 funds and Puerto Rico spending.

This next scenario is the same as the first, but instead assumes that Congress has provided sufficient federal funds to match all projected FY 2020 spending at the 83 percent FMAP that Puerto Rico would receive if its FMAP was determined through the same formula that state FMAPs are. So Congress under this scenario would need to appropriate at least $1.48 billion.

The next two bars shows scenarios in which Congress has not provided additional federal funds. So, in this third bar, that's outlined in red, Congress has not provided additional federal Medicaid funds beyond what's available under current law, but Puerto Rico maintains its expected FY 2020 contribution. So not all of the Puerto Rico spending shown in green would be matched. Some of it would be unmatched, and you can see that total spending

declines from about $2.8 billion to $1.8 billion.

This last bar here shows a scenario again in which Congress does not provide additional funds, but Puerto Rico reduces its own contribution. It would stop spending funds once it could no longer receive federal matching funds because the federal funding would have been exhausted. So total spending declines further to $1.3 billion.

Without additional federal funding, as I mentioned, spending reductions would require cutting benefits, enrollment, or both, and in the next slides, I'm going to go through and show what kinds of choices regarding benefits and eligibility that program administrators would face.

To achieve spending reductions without decreasing enrollment, Puerto Rico could eliminate optional benefits or reduce the amount, scope, and duration of mandatory benefits or some combination, and these slides show the makeup of Puerto Rico's projected FY 2020 spending by service category.

You can see that outpatient prescription drugs, which is this dark blue section, is the largest category in

terms of spending, at $808.6 million or 29 percent of funding for the fiscal year, and that is significantly higher than the national average share of spending attributable to drugs, which is 5.1 percent in FY 2017 after rebates. And we've heard from several stakeholders in Puerto Rico that this outsized share is more due to low spending in other benefit categories rather than higher utilization or higher than usual prices being paid for prescription drugs. For example, you heard from our panelists in December that provider payments have been chronically low.

You will recall that without additional federal funds, Puerto Rico would need to reduce spending by a little over $1 billion if it maintains its expected FY 2020 contribution, or about $1.5 billion if it contributes only enough to draw down available funds. So you can see here that even if you completely eliminated outpatient prescription drugs from the program, you still wouldn't achieve that level of savings here. Even if you added dental on top of it, you wouldn't achieve the level of savings that you would need.

Puerto Rico could also choose instead to cover

fewer people instead of reducing or eliminating benefits, and assuming no reduction in benefits, no additional federal funds, and the same territorial contribution in FY 2020, you can see that Puerto Rico would need to reduce enrollment by about 455,000 enrollees or 36 percent. If it chose to stop spending territory funds once it could no longer access federal matching funds, it would need to reduce enrollment by 669,000 beneficiaries or 53 percent.

Of course, Puerto Rico could use a combination, but these are just illustrative examples to give you a sense of the kind of spending cuts that we're talking about here.

So I'll stop there, but as far as next steps go, MACPAC will include this information along with information presented in prior meetings in a chapter in our June 2019 report to Congress. Feedback from you on the chapter's key messages would be helpful, and we'll welcome any other thoughts that you have or any questions we can answer.

CHAIR THOMPSON: Fantastic. Thank you very much. I mean, it's a sobering picture, but I think you've done a really good job of outlining a lot of different ways of looking at the challenges that are facing the commonwealth.

I'll just start off with a couple of observations in terms of thinking. I think all of the information that you've accumulated, including some of the information that we've previously discussed and that was provided to us earlier by stakeholders in Puerto Rico, I think it's going to be very useful information to include in the June report.

The one thing that I would say is that I think this gives us a really good picture of what is happening today, and even in the very near term in terms of looking at this upcoming fiscal cliff, but if we look at what the Congress was asking us for, they were talking about what is the answer for long-term sustainability. And part of that story, obviously, is that we have an immediate crisis. That is not something that you can ignore in answering that question.

But I do think this context is important for what you outline here, for example, in Figure 1, where we -- both in terms of what the federal government has done and an infusion of funds over time, and then that's not quite enough, and here's another infusion of funds. Was there a point when the commonwealth had more financial stability,

and what changed between those prior periods and these that we're looking at here today? And was some of that masked by the fact that the commonwealth might have appeared to have had more resources at its disposal, but it was actually engaged in fairly substantial borrowing at that point in time?

MS. BUDERI: This is not something we have a lot of data on. I think anecdotally, the story has been the last thing that you just said. I think Puerto Rico has been able to historically -- you know, I think Puerto Rico has gone through stages, of course, like any state or any government where they have more ability to pay for things than other times.

CHAIR THOMPSON: Right. You expect some cyclical. Right.

MS. BUDERI: Right.

I think when it comes to Medicaid, there has been a lot of Puerto Rico having to take on additional costs, and I do think that, my impression at least -- and we can look more into this -- is that a lot of that came from borrowing.

CHAIR THOMPSON: Yeah. Okay.

Martha.

COMMISSIONER CARTER: Thank you, Kacey.

Two questions. What services does Puerto Rico currently not cover at all that are common in the other states, in the states? Do you know that?

MS. BUDERI: The biggest one is long-term services and supports. Those are not covered. Non-emergency medical transportation. Those are the two big ones off the top of my head.

But they cover quite a few optional benefits, as I mentioned, prescription drugs, dental.

COMMISSIONER CARTER: But every state covers prescription drugs.

MS. BUDERI: Yeah, yeah.

The mandatory ones that they are not covering, the biggest ones, are LTSS and NEMT.

COMMISSIONER CARTER: And the second question, just to kind of wrap my brain around this, is there any question to compare the reimbursement rates to providers, to hospitals and primary care and specialist providers in terms of percent of charges or something?

Medicaid is already historically a low payer. So

how much worse is it in Puerto Rico is what I'm trying to get to, and if Puerto Rico chooses to cut services or reimbursement further if they don't get more money, what's that going to do to access to care? At some point, providers won't play when there's just terrible reimbursement, and they're probably already close to that. So can we flesh that out any?

MS. BUDERI: I don't think -- you can correct me if I'm wrong. I don't know that we would have the data to be able to compare that.

MR. PARK: Yeah. We don't have -- I mean, we can ask Puerto Rico if they can give us some information on payment rates for like a market basket of services, but we don't have data directly to answer that question.

COMMISSIONER CARTER: Okay. I wasn't sure if there was a way to compare that, but they can't be paying very -- I mean, they said they're not paying well.

MS. BUDERI: I think that there has been a lot of concern about the provider payment rates in Puerto Rico. I know that the Fiscal Control Board had had some plans to reduce rates further that were suspended because of the BBA funding at the 100 percent FMAP. I wouldn't be able to say

how soon those would get put back into place once the 100 percent FMAP went away, but I know that that's something that they have been grappling with in Puerto Rico because, as you heard on the December panel, there's been a lot of access challenges as well.

COMMISSIONER CARTER: Thank you.

CHAIR THOMPSON: We have Kit and then Peter.

COMMISSIONER GORTON: So sticking with this data for a moment, in terms of eligibility projections, I'm assuming, Chris, you used something that ASES gave you.

MR. PARK: That's correct.

COMMISSIONER GORTON: I'm just going to ask a question. I'm not expecting you to answer it, but we heard about the complete destruction of the island's health care infrastructure in late 2017. We heard about flight of professionals from the island at a massive level. We heard about huge inability to access health care services, and yet somehow they increased their spending in 2018.

I just want to put a question mark over that because we heard that several thousand people lost their lives. That's tragic. They were probably disproportionately high-cost, high-need individuals.

So just from a big-picture actuarial point of view, the shape of this curve doesn't make any sense to me, and it feels different to me. I haven't looked at these data in a long time, but it feels different to me than the data we saw coming out of New Orleans after Katrina, where the year after the storm, there was a huge dip in people's ability to get care. People went elsewhere, you know, basically more things.

And so I just want to put a question mark on the shape of this curve and essentially say, Chris -- and this may be more than you guys can do with the data. But I think we should speak a little bit to how many people are being served. What's the PMPM? What's happening to the PMPMs here? I think that maybe looking at these aggregate numbers, we're missing important observations. It just feels --

CHAIR THOMPSON: You mean by like different categories of beneficiaries so that we can see if there's --

COMMISSIONER GORTON: Yes.

CHAIR THOMPSON: Yeah.

COMMISSIONER GORTON: Because if we're -- and I

don't know what the ASES eligibility projections are. I think we should include those in the report for people to at least look at and be able to decide whether they find them plausible or not in the context of these other things that we're hearing.

But I think that I'm just having trouble reconciling all of these different pieces of observational data that people are sharing with the aggregate numbers that are being projected here.

I think back in 2015 in Boston. We had an event which we lovingly called "Snowmageddon," and the city was shut down for three weeks, which in Boston meant there was very little health care going on for three weeks. And the amount of money that didn't get spent during those three weeks, one, never got made back up and, two, was noticeable in all of the aggregate figures. So it's just striking to me that it doesn't show up here, and maybe there's an explanation for it. But I think we should look for it.

CHAIR THOMPSON: Yeah. I was going to actually invite Fred to respond to that question too about whether or not you saw similar patterns post-Katrina.

COMMISSIONER CERISE: I mean, to Kit's point,

there was a reduction. There was 100 percent federal funds for a number of things and spending for out-of-state activity at the time, but within the region itself, you did have a reduction because you didn't have the providers you were paying.

CHAIR THOMPSON: Darin, did you want to jump in on that point or a question?

COMMISSIONER GORDON: On that point and then one question on the graph.

CHAIR THOMPSON: Okay.

COMMISSIONER GORDON: On that point, you did see other surrounding states, though, where we also saw a lot of Medicaid folks from Louisiana that we did pick up. You did see that. So that is a factor there.

But on this chart, just make sure I understand what you're saying, you said that's going up in 2018. The way I read the chart, that Puerto Rico's contribution actually went down in 2017 to 2018.

COMMISSIONER GORTON: I'm just looking at the top line, the overall spending.

CHAIR THOMPSON: You're just still saying spending is spending. People are getting health care

services at that level.

COMMISSIONER GORDON: Okay.

COMMISSIONER GORTON: And the other piece is I don't know who's paying for it. So I don't know if you looked at -- I'm assuming that these are data that are reported for services on the island. If what we're talking about is what ASES is paying for in New York and Florida and other places, then that might be an explanation for this, and we may need to ask them whether they were buying a lot of services for people in contiguous jurisdictions.

CHAIR THOMPSON: Kacey, Chris, any response to Kit's questions about that or whether we know some of the details he's asking for?

MS. BUDERI: This graph right here is total spending. So I would have to get more clarity about whether it includes off-island services.

In terms of the capitation rates and whether they changed, we do have the capitation rates for, I think, 2017 through 2019 and then projected for future ones. So we can look into that.

I know they changed the rates pretty substantially because they began -- they did their managed

care reform in October of last year. So that's when the big change happened.

COMMISSIONER GORTON: Right. And I guess what I'm interested -- so I'm less interested -- obviously, I'm interested in the financial health of the managed care plans, but I'm interested in really what the cost structure is doing. So are they projecting increases in medical expense year-over-year? What is that component versus the eligibility? That is really the bulk of my question. Are we seeing more units of service? Are we seeing more expense of services? Are we seeing more people being served?

The reason I bring that up is because then when you get to your various scenarios, I think it really matters what we're assuming, you know, what the projections include in terms of eligibility and access to services. I just think it would help me at least to understand a little better what it is that we're trying to accomplish.

CHAIR THOMPSON: Good. Okay.

All right. So I messed up the -- who was trying to get in here. I have Peter. I have Bill. I have Melanie. I have Toby and Brian.

COMMISSIONER SZILAGYI: Thanks.

Could you go to Slide 11? How does Kit's question relate to -- I had a question about this slide, anyway. Is the $2,144, is that basically a per member per year?

MR. PARK: Yes. That's spending per full-year-equivalent, so per member per month times 12.

COMMISSIONER SZILAGYI: So maybe it went up, but it's still lower than all 50 states. It's a third the median.

MR. PARK: Yeah. It definitely went up. I don't have all the data in front of me to know exactly how much it went up.

COMMISSIONER SZILAGYI: But it's still incredibly low. So I don't know whether that partly relates to maybe what Kit was asking. Maybe it's a lot more enrollees because they were eligible, but it's not the spending per year.

My question was, do we know whether that number is relatively stable going back? Is this striking number that it's less than every other state? It's a third of the third percentile? Maybe it's the median.

If you went back, would it be about the same? Do you know?

MR. PARK: I can take a look at the data that Puerto Rico has given us since they did include some months before the period that we looked at in terms of fiscal year '18.

COMMISSIONER SZILAGYI: Just to make sure it's not some sort of --

MR. PARK: Right.

COMMISSIONER SZILAGYI: My other question was we heard about two types of flight -- the massive flight of professionals to Florida and other places and the massive flight of patients. And then I think what we heard last time is that some of these patients are getting care in the other states at a much higher cost. Is there a way of modeling, making some reasonable assumptions if a certain number of patients lose Medicaid and therefore -- or some to the states because of problems in Puerto Rico, what the costs would be for the federal government?

So if a third of the patients come to the states at the median cost, it would be actually more expensive for the U.S. government.

Do we know about the reasons for the flight for patients, how much of that was driven by health care?

MR. PARK: I don't think we can discern like why they might have left the island. We could do the math, certainly, to say like if this number of people left.

COMMISSIONER SZILAGYI: It's the assumptions that's probably harder than the math.

MR. PARK: Right.

EXECUTIVE DIRECTOR SCHWARTZ: We also don't know who left and what kinds of health care users they were.

COMMISSIONER SZILAGYI: What kind of classes.

EXECUTIVE DIRECTOR SCHWARTZ: Were they high-cost users? Were they low-cost users? Were they not on Medicaid?

We also asked CBO if when thinking about future federal funding, how would they consider cost to other states' Medicaid programs, and they said, "We don't do that."

So it's not that those costs don't happen. Just in their model, they would not include that.

COMMISSIONER SZILAGYI: It's not modeled.

EXECUTIVE DIRECTOR SCHWARTZ: Right.

COMMISSIONER SZILAGYI: Okay.

CHAIR THOMPSON: Bill.

COMMISSIONER SCANLON: Actually bringing up a slide is helpful.

I have no disagreement with the issue about the magnitude of the problem and that something needs to be done. It's more a question of focusing on what we should think about in terms of what needs to be done, and this chart to me in some respects is more about an equity statement. We've got these limitations on what the federal government is supporting in Puerto Rico historically. Yes, there's been supplements, but historically, it was fixed at 55 percent, and as you point out, if we would apply the ordinary FMAP formula, it would be 83 percent.

I think Puerto Rico is acknowledging this with their alternative poverty measures. It's almost as if we're talking about a different scale and that Puerto Rico is on euros and we're on dollars. I mean something sort of along those lines.

In our DSH recommendations, we said -- and DHS reallocation recommendations, we said we should be taking into account geographic differences in cost, and I think

the same thing would apply here too, which is what does 2124 mean after you've adjusted for the cost of care?

There can be two things that are happening there. One is that there are just differences in cost of living, and so on the non-Medicaid side, there's different costs for providers to deliver care. And then on the Medicaid side, part of that reflects just potentially low Medicaid rates, and I think if we had some of that information, it would go to what Martha was talking about.

I don't know if it's easy to get a Medicare hospital wage index for Puerto Rico, the way it's used for the other 50 states, but that's potentially a data source to adjust comparisons sort of like this.

MS. BUDERI: So I don't have data in front of me about this, but my understanding is that the cost of living and the inputs are actually pretty high in Puerto Rico because it's hard to get things there. The cost of living is higher than you would expect. The cost of bringing things there a relatively fixed in terms of all the other inputs that go in to determining the costs here.

So I can try to get some data on that. I know there's been some issues with the way the Medicare hospital

wage index has been applied for Puerto Rico also. We can look more into that, and hopefully, we can include something in the chapter.

COMMISSIONER SCANLON: That actually would also sort of add to the understanding of the situation because they've got a lower poverty level, sort of standard, and yet they have so many people in poverty that are qualified for Medicaid. So it makes it even more sort of telling in terms of the problems faced by people in Puerto Rico if you've got this size of the population that's in poverty by a lower standard, and yet the cost of living is high.

CHAIR THOMPSON: Melanie.

COMMISSIONER BELLA: Thank you.

I'm having a hard time getting my head around the magnitude of this and kind of we've been thinking about how to address it. So I have a couple of very narrow, concrete questions, and possible steps.

Have we seen in the past a breakdown of eligibility and PMPM and growth over time by eligibility categories? I'm really curious about it. I guess where my head is going -- sorry, Chris. Let me let you answer.

MR. PARK: I was just going to say OACT, when

they do their actuarial report for Medicaid, does have historical spending per FYE, the major eligibility groups in the states, but they don't do that for Puerto Rico.

COMMISSIONER BELLA: So we don't have any sense of that?

MR. PARK: We could try to see what Puerto Rico could provide us, but I don't know if we would be able to do a historical time frame with that.

CHAIR THOMPSON: But if they had it, we would have a point of comparison to the other states.

COMMISSIONER BELLA: Yeah. And so my second question on data -- and I'm guessing this is definitely no if we don't have the first -- there is some belief -- I think many believe that there's a relationship between Medicaid and LTSS spending in Medicare post-acute spending, and so there is no Medicaid LTSS benefit here. Almost everyone is in a D-SNP there.

Have we looked at Medicare spending in Puerto Rico? And I'll get to why I'm asking that in a second. Do we have anything on that?

MR. PARK: We haven't looked at that, so I'm not sure what is available.

COMMISSIONER BELLA: Okay. Well, I guess where my head is going is it makes me -- I understand why we talk about a solution would be cutting services or benefits or eligibility, but it makes me really nervous. It helps paint the picture of like how big that would have to be, but having run a Medicaid program, you can't cut yourself out of these things because you're not addressing -- you're cutting rates, and the next year, you're still going to have to cut more rates or cut more services. And you run out of stuff.

And so I'm just curious like what the opportunity is from a quality improvement or outcome improvement standpoint so we can understand like is the spending in Puerto Rico -- do they have a sicker population? Is there opportunity to drive efficiencies in ways that are going to take a little bit of a long-term investment, but we at least understand that there's opportunity there?

And I think it also like -- we've got to make sure that we also are thinking of not just shifting cost. So we could cut prescription drugs, but then we have to recognize the increase that we're going to have over here. Just like my question about by not serving long-term care,

like what are we doing to the Medicare side of the house?

And so trying to paint a picture of what's the totality of sort of federal dollars going on in Puerto Rico, and how could those be better allocated? And are there ways then to put some of that funding toward this problem here? Maybe Congress says you got some sort of value-based arrangement with Puerto Rico, and we say there's an opportunity over three years to drive down costs by these ways, but we don't even know if like what -- I realize it's all managed care plans. So we don't even know if they are providing high-quality care. That if we have an opportunity to drive costs down through improvement or if we -- or if they're already managing the population pretty well.

I mean, it just feels like there's things that would be helpful to know to help understand what the possible solutions would be. They're all going to require more money, though, in my opinion.

CHAIR THOMPSON: Brian. Let's see. Brian, Toby, Fred.

COMMISSIONER BURWELL: So a number that was interesting to me is the number of mandatory Medicaid

spending reductions of $826 million imposed by the FOMB, and to me, that implies that there is a larger part of the story here.

I mean, I assume the FOMB came into existence prior to the hurricane to deal with Puerto Rico's overall debt problem, which was significant even before the hurricane. So, to me, this is another pain point that has to be taken into account in terms of financing the Medicaid program. That the FOMB is imposing austerity measures in the Medicaid program partly due to the underlying debt problem that Puerto Rico has.

So just spending more money on Medicaid isn't going to address that larger issue. I just think that these two problems -- I mean, it was a really bad situation prior to the hurricane, and now it's like really bad. I don't see how we can talk about one without talking about the other. That's all I --

CHAIR THOMPSON: Well, and what I would say even beyond that, Brian, to build on that point is -- is where I was going with my earlier question, which is there was this financial set of issues and then the hurricane, but prior to that, I don't know that we would look and say, well,

everything was working.

So there was a long period also preceding that of crisis faced and averted. So we keep layering on these stresses on a system that's unable to absorb it and again kind of facing the situation where we now need rescue, and I think that's why Congress is sort of asking us the question, though obviously it's not something that's easy to answer, which is -- and where Melanie was going, which is where is the longer-term answer where you can see some kind of pathway forward where we're not continuously in this emergency situation.

It would be interesting to say a little bit more about this to the extent that you guys have more insight, Kacey and Chris, on even what the FOMB has come up with and the skepticism that some of the stakeholders have about whether these savings projections will be realized or not through these improvements.

We're going to presumably do something about prescription drugs -- I'm not exactly sure what -- and we're going to address fraud and abuse or medical necessary or something like that. Are there details underneath any of that about whether there are actual specific steps that

are going to be taken and how the estimates are derived of the savings that are going to be driven through those steps?

MS. BUDERI: There are few more details, but not that many more.

EXECUTIVE DIRECTOR SCHWARTZ: The Board's documents in some sense look like a list that you would have seen in any number of Medicaid cost containment efforts, from very large things to things like increasing copays for non-emergency use of the emergency room, which may or may not result in savings.

CHAIR THOMPSON: Right.

EXECUTIVE DIRECTOR SCHWARTZ: When we asked them, when we saw the projections of their capitation rates, we saw the amount they are going to spend on capitation rates this year and then future rates that were much smaller, the next year. We asked, "What's happening there? How do you get there?" It makes me think of that New Yorker cartoon where the guy has his equation, and then there's like dot-dot-dot. I think there's a lot of ideas and an expectation that they will get the cost savings but a lack of specificity about what would really happen.

CHAIR THOMPSON: That is that black box --

EXECUTIVE DIRECTOR SCHWARTZ: Exactly.

CHAIR THOMPSON: -- or it's like magic happens here.

EXECUTIVE DIRECTOR SCHWARTZ: Right, right.

CHAIR THOMPSON: Yeah. Okay. Toby and then Fred.

COMMISSIONER DOUGLAS: So my question is more about the June report. I am just thinking about the last meeting where we talked about is there opportunities to highlight areas where there could be -- besides on the spending side -- and it's building on what Melanie said -- are there opportunities to provide flexibilities, whether it's -- back to the payments, there is a heavy reliance on federally qualified health centers, so their interactions with funding with HRSA as well as approaches on PPS that might allow for flexibilities. The same goes with telehealth. So I don't know where that all fits into the June report. So it's more of a question to Anne and to Penny.

CHAIR THOMPSON: I guess I would say as a matter of process, we're here just really kind of like being fed a

lot of information through a firehose from the last couple of sessions, including this one.

I don't think we are at a point where we have formulated a direction or recommendation such that we could be voting on anything next month, and so that's the schedule that we would have to be on in order to get to a June report with that.

I think my view would be -- and it could be something for Kacey and Chris and Anne to comment on -- that the focus on the June report is pulling this information together in a digestible format because I think there is a lot of good information that we've collected that isn't necessarily at least easily accessible or even available in the format that we have it, and then set up for -- again, because there is no deadline on recommendations, to be able to continue that work and maybe hone in on some of those ideas perhaps in the fall.

COMMISSIONER DOUGLAS: Then the only -- and I guess I know it's a little out of our -- but just understanding these other funding streams is still, if that's a data point that we could get, just to understand the context of what they're receiving related to health --

whether it was HRSA or SAMHSA funding, any infrastructure for telehealth, all these different pieces, where do they fit in, to understand the broader context.

CHAIR THOMPSON: Fred.

COMMISSIONER CERISE: Kind of on your point, Penny, Medicaid is designed as a comprehensive program, and you see that you've got pieces of a Medicaid program here. So 55 percent match, that's not appropriate for the population, the cap, and so you've come in with these multiple fixes over time, and so it just seems like it's very difficult to have kind of sort of a Medicaid program which is where you are.

I'm concerned about approaches that would extract savings out of the program. When I see the slide that shows how low that PMPM is and we hear about the providers that are leaving -- so notwithstanding Kit's point on what's actually going on there, I saw those -- the line said those were projected too. I don't know if those are -- like '18 is an actual or -- yeah. So I didn't know if -- so '18 is projected too. So maybe that's not where that lands.

But it seems like we're struggling with just this

-- it's a post-storm program, but it's got some fundamental issues that are just not going to work for the Medicaid program.

One point, as we grapple with this, timing is important, right? It's very difficult for the program people to know what to do if they're going to run out of money in March of 2020 because, as you know, all of these things take time to do. So that's a plea for if we're going to do something, time is important here.

It seems like there's -- I don't know how to get around something like a big idea here that the Medicaid program -- you're trying to run a Medicaid program without the tools to run a Medicaid program.

And then just one specific observation, it's around the pharmaceutical spend, where I think you said it's at 29 percent. You can look at everything else perhaps that's down at a low rate, and the thing that stays at a high rate is the drug cost. I wonder if there's anything to say or propose there around drugs and rebates in an area where, as Bill said, you're sort of on a different scale.

If that's the only thing that stays sort of at

U.S. market rates, then it's going to keep going up from 29 and get a lot worse. So I don't know if there's anything specific you can do around drug prices or rebates or something for Puerto Rico.

EXECUTIVE DIRECTOR SCHWARTZ: I think there are probably also some other ways that we can array the data to provide some more context.

For example, on the slide with the actual and projected spending, look at what the trend would be across other states, too, to sort of give that some context.

CHAIR THOMPSON: Alan.

COMMISSIONER WEIL: I guess I want to express a slightly inchoate sense of discomfort here. We've been asked to look at long-term sustainable access to care for Medicaid beneficiaries in Puerto Rico, and I do feel like we have two really different things going on.

One is post-hurricane crisis that basically, so far as I can tell from what you're showing us, there was a bail-out, if you will, and it's going to come to an end, and it reminds me of the enhanced match in the ARRA. Whenever some extra comes to an end, it looks like a crisis, and the question is, are you ready to pick it up on

your own?

But in this instance, based on what you're presenting, it does appear that the crisis preexists, and in some sense, the extra funding made it possible to get through things that were really problematic beforehand.

So my discomfort is I hear all the questions and I think they're good questions, but I don't know that we have the capacity to figure out how Puerto Rico should manage its Medicaid program.

I just worry about -- I'm trying to play Anne here for a moment. We could just keep peppering you with analytic questions to come and compare and contrast and this and that, but I'm not sure that that's really what's going on here. I mean, we're dealing with a relatively poor jurisdiction with a struggling infrastructure.

Anyway, as I say, it's somewhat inchoate. I'm trying to figure out what our end point is before we just have you answer a bunch of questions for us.

CHAIR THOMPSON: Yeah. I think that's right, and that's a little bit of where I was trying to go with that we just keep lurching from one crisis to another, and even in a prior period predating some of the information that

we're looking at here, the commonwealth may have well kept its program afloat as well as other things by engaging in some borrowing that may not have been the -- you know, may have been the way that they were addressing it.

So it does seem to me that there's sort of a -- and, Fred, I think this is the point you're making. There's some fundamentals here.

But, at the same time, the ability to dive into that and peel apart, so this is how it could be different, I think is the question that you're raising, Alan. Where can we go with this in a way that's really productive of our time? As opposed to what I think we certainly can do, which is pull together this picture that we've created, which I think is very useful to people.

Now, we're not compelled to make recommendations. So if we as a Commission believe that we've done what we can, we've provided some information to people about the state of play, but others should pick it up and sort of now talk about what restructuring the program should look like from a programmatic standpoint or from a financial standpoint, we could choose to do that. It sort of depends on where we think we really could dive in and think about

something that could be helpful to people.

Alan, yeah.

COMMISSIONER WEIL: If I could just add, my understanding is limited here, but my sense is that Puerto Rico went from basically a public health model to a managed care model. It has essentially no private insurance, and so a lot of the tools that we think of around alignment and incentives, they sort of did that.

So I think if we're going to have this question again, it's not just about levels of dollars. It's like when you constrain the resources, people do the best they can, but it's sitting on top of a very different structure than it was years ago and with a very different set of financial hydraulics, given that we talked about DSH underpayment. There is no one making the overpayment there.

CHAIR THOMPSON: Kisha.

COMMISSIONER DAVIS: Yeah. I think I get more baffled as we continue to go on.

One of the things I think I just want to make sure that we address as we have talked about, as Melanie said, there is no way to really cut themselves out of it.

They've cut and cut and cut, and we can't re-create their program. But I just want to make sure that we, in dealing with the issue and addressing recommendations, are thinking about the funding levels specifically, even if it's not necessarily giving funding levels, but what -- the implications, you know, this program isn't funded enough, and that, you know, hurricane or no hurricane, that was something that was going on long before. And the hurricane, if anything, probably helped avert the cliff and push that back a little bit because of the infusion of funds.

To Alan's point, what are the structures that have put this in place, and are there things that they need to be thinking about or that the government needs to be thinking about in terms of funding that will change that for the long term? And tweaks around the sides, whether you include drugs or dental or not, aren't going to fundamentally change the program and how it's funded, and that needs to be -- to the question to us about what are the long-term things that are going to help it, just making sure we're looking at that.

CHAIR THOMPSON: And to some extent, if we could

put up Figure 3, that's a little bit of where you were trying to go with Figure 3, right? I mean, it's only speaking to 2020, right? Yeah. In terms of things that you could potentially change and where funds can come from and what kind of structure you're looking at and what overall level of funding that provides and then what that compares to in terms of other kinds of programs.

Melanie.

COMMISSIONER BELLA: Maybe this is Fred who said this, but I guess if we're calling this a Medicaid program, then why aren't we having a conversation about being bold enough to say fund it like a Medicaid program? Is that a third rail saying that as a Commission like we don't want to go there?

I appreciate Alan. I was actually sitting here thinking, well, they could save by doing this sort of thing, and he's right. We're not going to tell them how to run a program, but if it's a Medicaid program, it needs to be funded as such. Why wouldn't we consider making that strong of a recommendation? They can choose -- it just feels like that's the elephant in the room that we're not talking about.

So I'm curious why we wouldn't just say fund it.

CHAIR THOMPSON: Is that not the second column?

MS. BUDERI: Yeah. This column is basically saying if enough federal funds were available to match Puerto Rico's expected expenditures, this is what the distribution would look like, but it's not saying how that federal funding would be provided. There are options for how to do that.

COMMISSIONER DOUGLAS: [Speaking off microphone.]

CHAIR THOMPSON: Use your mic, Toby.

COMMISSIONER DOUGLAS: I said nor is it dealing with eligibility. Sorry.

MS. BUDERI: Right. this would assume that they maintain eligibility at 133 percent of Puerto Rico poverty.

COMMISSIONER DOUGLAS: Yeah. Which if Melanie is saying we treat it like a Medicaid program, you'd have to model both, both the FMAP as well as the overall --

EXECUTIVE DIRECTOR SCHWARTZ: But if you went to an eligibility level that was comparable to the states, it would be even bigger, right, because --

COMMISSIONER DOUGLAS: Yeah, yeah.

CHAIR THOMPSON: Chuck, do you want to jump in

here?

COMMISSIONER MILLIGAN: Yes. Unfortunately, I do.

I want to go back to Kisha's comment. I align myself with what Melanie and Toby were just saying, by the way, but I want to go back to Kisha's comment.

If the crisis predated the hurricane in certain ways, in certain important ways, and if the hurricane may have actually helped in terms of the funding stream, I know that the June chapter -- I think the June chapter, Puerto Rico focus, makes a lot of sense and all of that stuff, but to me, the context then becomes this is a territory's issue because if it's not a hurricane issue, is this a territory's issue?

That's kind of a lot to kind of bite off, and it's certainly -- but we can't get there by June. But I just -- sorry. I've got a heckler.

[Laughter.]

COMMISSIONER RETCHIN: Wait a minute. You want to talk about heckling.

COMMISSIONER MILLIGAN: To Melanie's comment, should we treat it like a Medicare program, I just think

that becomes then a territory's question, more so than a Puerto Rico question, if the fundamentals aren't really about the hurricane, but it's about some of the other dynamics unique to territories.

CHAIR THOMPSON: Yeah. In addition to the many other questions that we asked you all to consider earlier -- and I appreciate your mentioning this at the top of your presentation -- we had talked about how different is Puerto Rico than other states, and we had also talked about how different is Puerto Rico than other territories.

You mentioned that, hey, don't ask us anything about these territories because we can't get the information to talk about that.

But is it not also -- but I think it is true what Chuck is saying, which is you can't really equitably talk about Puerto Rico without talking about to what extent those same questions get raised and answered in a same or different way with regard to other territories.

But it is true, correct, that there are differences among the territories. So they are not a monolith, both in terms of -- well, just everything. Just like any other state, states vary; territories vary.

But even in terms of some of the financing pieces can vary from territory to territory, correct?

MS. BUDERI: Yes. I think it would be fair to say that all of the territories are also going to experience their own fiscal cliff. I think they're all grappling with the same challenge. All of them are grappling with this. Some of them grapple with the matching rate more than the available funds, but those two issues are interrelated.

EXECUTIVE DIRECTOR SCHWARTZ: But wouldn't it be fair to say, Kacey, that the financing structure is the same for all the territories, but how they actually run their program is the thing that is significantly different?

MS. BUDERI: That's right.

EXECUTIVE DIRECTOR SCHWARTZ: Let me just also add here Kacey with the help of Chris and Joanne and others have been working on a brief on when all of the territories will be expected to exhaust each of these buckets of funds. We keep thinking we're at the finish line, and then we keep asking other folks, "Are these numbers correct?" and we keep getting different answers.

We should have that out soon, and so that we will

be able to contribute something to discussion on the other territories.

I also want to say it's sort of shocking to me how little information is available, and as many questions as you all have, really detailed, important questions -- I can see where they come from your own experiences, running or assessing these programs. Nobody else is doing this analysis who is not in the thick of it.

Obviously, Puerto Rico has a lot of skin in the game, and they're doing a lot, but there are not really many other groups that are looking this deeply into the financing and the flow-of-funds issue.

CHAIR THOMPSON: So I want to come back and maybe suggest that in addition to the work that you're doing to kind of pull this together for the June chapter, I want to respond to the interest of Commissioners in terms of thinking about how to present maybe an alternative way of thinking about it if we were to treat Puerto Rico like any other Medicaid program.

I think it would be interesting in addition to what you're doing here in Figure 3, but I think we need to bring it home a little bit more.

I think it would be interesting -- and you can think about whether this is something that's worthwhile doing or that you could do. If we had not over the past however many years for which we have good data been in this mode of here's a bunch of money, here's now a new pot of money and we just had from that earlier point in time not had a cap, done a match, would we be in a significantly different place? Would we have put out the same money, anyway?

The question I am asking is to that question of stability and sustainability. That if we put ourselves in an emergency situation and constantly have to go try to find the way of dealing with the emergency, not only are we putting the program in a difficult place operationally, we may not actually be altering the equation in any significant way. That's a question. I don't know the answer to that.

But I do think that we have seen these cycles of crisis and rescue, crisis and rescue, and crisis and rescue. And I think there's no one here that would say that's the best way to go about business, and if we keep repeating this cycle, that's the cycle that we've been in.

If we conceived of a different way of organizing the federal and state relationship, maybe with variables that you could play with a little bit, maybe that's a point of conversation in the meeting next month that could be kind of a focus of conversation to see if there's some more that we want to say around those elements as part of this June chapter, again, not necessarily with an ambition to make any kind of recommendations, but in the same kind of way that you're trying to line up where the spending has been and where the funding has come from and what it looks like with regard to other states and so forth. It might be also worthwhile to think about other models of federal, state financing and what that could have done or would do if we contemplated it differently.

Sheldon.

COMMISSIONER RETCHIN: First of all, I really like the idea of going back and looking at these episodic funding that makes it unpredictable in terms of the sustainability and has people, both potential beneficiaries as well as health care workers, dealing with the uncertainty by leaving.

And so getting back to something we opened this

up with that we couldn't get data on people leaving or maybe it's very difficult to get it -- I guess that's what we said -- I would still like to come back to the qualitative effect of the exodus of health professionals.

I guess it's not our role, but someone could conduct surveys or look at, in this case, real exit interviews, to look at how much this plays a role, because -- and the reason I think it's important is because you have these, in this case, sort of border stakes that are most affected that have constituents and that have leadership, both in the Senate and in the House, who would probably get engaged in this. I think that it's important qualitatively for Congress.

CHAIR THOMPSON: Okay. Any final thoughts from the Commissioners?

[No response.]

CHAIR THOMPSON: I'm just going to provide one quick opportunity for the public to jump in on this discussion and say anything you'd like to say.

PUBLIC COMMENT

* MS. HALL: Hi. Cornelia Hall from Kaiser Family Foundation, also working on this issue, and I always

appreciate more data and spending number so thank you for all that.

I just wanted to touch on a couple of questions, because my colleagues and I were just in Puerto Rico and the Virgin Islands last week, conducting interviews with plans and providers and other folks on these questions.

So regarding the question of the spending going up, I don't have any numbers, but just some factors that may have contributed to that. They did suspend the renewal requirement for 12 months after the hurricane so that might have affected the eligibility and the enrollment numbers that could have contributed, and also temporarily increased reimbursement rates, which would also go back down after the fiscal cliff. It may have contributed as well.

COMMISSIONER GORTON: And I'm assuming that having stopped doing redeterminations and bumped provider rates, they also maintained the planned capitation payments that they were already making.

MS. HALL: Yeah, although this new managed care system is rolling out -- I mean, it started rolling out, I guess, in the fall.

COMMISSIONER GORTON: All right. But so if

you've -- the potential exists that these spending numbers are higher than either was experienced or was higher than was necessary because the people and the providers -- the people who are being cared for -- who are supposedly being cared for and the providers who are being paid, who are no longer on the island, eligibility numbers may have gone up if incomes dropped. I mean, I just think there's just a whole lot of moving parts here. I'm glad you've flagged the unit cost piece. It would be interesting to know how long they expect that to go on.

But I think -- and I take Alan's point that we don't -- you know, we're asking a lot of detailed questions, but at some point we're going to potentially say, you know, there needs to be more money in the program, and somebody is going to say, "Well, how much more?" And it would be nice to have some sense of what that's going to look like. So I --

MS. HALL: Yeah. Well, and to that point, the elected officials from Puerto Rico and the other territories have kind of put some numbers on that. You know, there was a -- they all testified -- the governors testified in front of the Senate Natural Resources

Committee last week, with some numbers on this, and then the delegate to Congress from Puerto Rico had a press conference yesterday about a bill, with Stacey Plaskett from the Virgin Islands, a bill asking, you know, increasing the cap, I mean, the FMAP, and changing the cap. So that might be useful.

And then, quickly, on the PMPM, the managed care reform is really an overhaul. I mean, we heard that providers are grappling with now dealing with five different plans instead of one. They all have different requirements for high-cost, high-need patient programs. There are now 37 different, I think, rate cells, which is a big change from before. So that is something to consider too. And, quick plug, will be coming out with a report on this in the next couple of months so always happy to --

[Simultaneous conversation.]

CHAIR THOMPSON: That will be helpful too.

MS. HALL: Thank you.

CHAIR THOMPSON: Yeah, and, you know, and that's sort of -- the idea that they are in a transition on their health care delivery system also brings me a little bit of skepticism about savings delivery. I don't know if you

would agree with that, Stacey, or not. But just not that actuaries don't do an excellent job projecting savings. But, you know, it just takes --

VICE CHAIR LAMPKIN: I'm not sure that's what I was agreeing to.

[Laughter.]

CHAIR THOMPSON: Yeah. But just that, you know, it can be difficult for a health care system to absorb change and to then start to get through those humps before they can actually start realizing the benefits of the change that people want to invest in.

Okay. So I think I'll leave this with, you've gotten some additional questions. I think we all appreciate that some or curiosity or questions may not have easy sources for data. I do think some of the questions, including the ones that Kit was raising about, like, let's really try to understand some of these patterns in spending, and if decomposition of that will be helpful, if that's available we should do that.

I would like to see this on the agenda on April, just to circle back around with the state of the chapter,

and kind of, if you don't have a full chapter at least the outline of the chapter, so that people can have the --

EXECUTIVE DIRECTOR SCHWARTZ: We will have the full chapter for April and you will have an opportunity to massage it.

CHAIR THOMPSON: Okay.

EXECUTIVE DIRECTOR SCHWARTZ: Yes.

CHAIR THOMPSON: And, you know, I think if there are some of these additional details that we can touch on, I mean, without going through all of the conversation that we've gone on, but in terms of following up to some of the questions that we've talked about here, for explaining spending and maybe going back in and modeling what would have been, what could have been under a different scenario, I think that that could be useful to have the Commissioners react to that in terms of helping to finalize the chapter.

And, of course, we will be happy to absorb anything Kaiser puts out in the interim, as well. Thank you.

Okay. Ready to move on to the next topic.

VICE CHAIR LAMPKIN: So now we are welcoming Jessica back to continue our conversation about program

integrity and potential recommendations that we may consider. Thanks, Jessica.

RETURN ON INVESTMENT FOR STATE PROGRAM INTEGRITY STRATEGIES: POTENTIAL RECOMMENDATIONS

* MS. MORRIS: Thank you. Good afternoon. In this presentation I will provide a brief update on Medicaid program integrity, a review of our findings from our last recommendations in this area, as well as proposed language for two potential recommendations and the rationales behind them.

State Medicaid programs have primary responsibility for program integrity, which includes a wide variety of range of initiatives to detect and deter fraud, waste, and abuse and improve program administration. PI consists of many activities, including some that are embedded in larger programmatic functions such as individual and provider enrollment, service delivery, and payment, and other dedicated program integrity activities that cross multiple functions, such as post-payment review.

However, as the Commission has noted in prior reports, states must continually strike a balance between having effective PI strategies and addressing other program

goals.

Lastly, CMS officials provide states with technical assistance and agency guidance on certain PI activities but has not focused on measuring the effectiveness of these activities.

While there is widespread agreement that the federal government and states should focus resources on areas of risk and invest in approaches known to work, there is little information on where or how to focus. In 2012, the Commission made a recommendation that the Secretary should determine which Medicaid program integrity activities are most effective, take steps to eliminate redundant and outdated programs, develop methods for better quantifying the effectiveness of different PI strategies, and improve dissemination of best practices.

We reiterated these recommendations in a June 2017 chapter on program integrity and managed care. However, to date, those recommendations have not been a part of the Department's Medicaid program integrity strategy.

To shed light on this issue we contracted with Myers and Stauffer to collect information from states on

how to measure performance and return on investment from a number of PI approaches. We found states had little information on the relative value of PI activities and seek CMS guidance.

For example, the Recovery Audit Contractor Program was made mandatory by Congress in 2012 to maximize returns from post-payment reviews. However, about half of states find the program financially unsustainable. They seek waivers every two years and rejustify their exemption from the mandate.

It remains difficult for states and the federal government to identify and prioritize best PI practices. States do not have an incentive to measure the return on mandatory activities, could not establish the cost estimates associated with the program integrity activities embedded in broader programmatic functions, and some states generate benefits that cannot be easily quantified.

In our review of PI activities we found that the Secretary has not fully acted on the Commission's 2012 recommendations to develop methods for quantifying the effectiveness of different PI strategies, citing the complexity and variation across state Medicaid programs and

payment systems. The Secretary has also not fully acted on the Commission's 2012 recommendations to improve dissemination of best practices. CMS' Medicaid integrity plan includes several approaches for collecting and sharing information among states. However, our study found that most states rely on informal channels for learning about other states' practices.

States are not well positioned to determine the effectiveness of program integrity approaches on their own. The implementation of outdated, redundant, or duplicative programs can have negative effects on providers and beneficiaries as well as states. For example, providers are required to comply with medical record requests and other audit requirements. Overlapping post-payment reviews can increase the burden on providers without providing new information. In addition, administrative resources that are directed towards activities that are duplicative or ineffective cannot be used to invest in other approaches that could provide greater protection for beneficiaries and program spending.

In response to these findings and a perceived lack of response for the Secretary to MACPAC's 2012

recommendations, the Commission directed staff to develop recommendations for the federal government to establish state-level program integrity demonstrations and use the results to help improve Medicaid program integrity activities, and for Congress to change the statute so that states have the option, rather than the requirement, to contract with a RAC.

Therefore, the first recommendation we are proposing could be directed to Congress or the Secretary of HHS. Specifically, the recommendation reads, "Congress or the U.S. Department of Health and Human Services should, under the Medicaid Integrity Program, establish experiments and demonstration projects to identify effective program integrity approaches and provide states with information to improve program integrity operations and performance."

HHS' statutory authority under the Medicaid Integrity Program allows the agency to work with states and take a lead role in developing and disseminating information on the effectiveness of Medicaid program integrity approaches, including support and assistance to the states to combat provider fraud and abuse; to provide guidance and oversight, education and technical assistance,

and federal resources.

Creating a federal demonstration program that would work with states to test program integrity models could mitigate many of the challenges states are facing in trying to determine the effectiveness of PI approaches on their own. It could compare the effectiveness of different approaches in a comparable manner, and it could determine the factors that account for variations in the success of certain PI approaches and strategies across states such as different payment models, the use of managed care contract terms, the use of contractors, or the effect of state operational structures, among other factors.

The Commission has the option to decide whether a stronger recommendation would be for Congress to direct the Secretary to use its existing authority to establish demonstration projects to identify effective approaches.

The change would require the Secretary to create new demonstration projects. The CBO does not support recommendations as a saver or a cost to the federal government if they do not change statutory authority. This change is intended to provide states with additional information on the effectiveness of various program

integrity efforts which may lead to program efficiencies. States will have the option to participate in demonstration projects. The elimination of outdated, redundant, or duplicative PI programs may reduce administrative burden on states and providers. It is unlikely that this change would have any measurable effect on beneficiaries or MCOs.

The next recommendation we are proposing has to do with the mandated RAC program. Specifically, the recommendation reads, "To provide states with flexibility in choosing program integrity strategies determined to be effective and demonstrate high value, Congress should amend the Social Security Act to make the requirements that states establish a recovery audit contractor program optional."

The RAC program has not been shown to be effective for all states and is an administrative burden on state Medicaid agencies due to the time and resources it takes to solicit a RAC vendor, manage multiple failed procurements, preparing a waiver application, renewals, and reporting. Because the requirement for states to establish a RAC program is in statute, a recommendation to Congress is necessary to amend the statute to make this provision

optional.

This recommendation would require CMS to review state plan amendments for states that opt to work with RAC vendors but would no longer need to review waivers of this requirement. The CBO estimated this recommendation would increase federal spending by less than $50 million over one year.

This recommendation would give states the option to determine if they want to implement a RAC program under the terms they choose to outline in a state plan amendment. They would no longer be required to procure a RAC vendor or pursue a waiver if they are unable or unwilling to implement a RAC program. As a result, some states would be relieved of the administrative burden associated with the waiver application process for a mandated PI activity.

It is unlikely that this change would have any measurable effect on beneficiaries, providers, or MCOs, though we anticipate providers would still be required to address improper payments and respond to investigations that may lead to recoveries of overpayments.

That concludes my presentation for today. I look forward to any feedback you have on the two proposed

recommendations and key themes you'd like to highlight in the June chapter. The plan is to vote on any recommendations at the April meeting and to provide the Commission with a draft chapter based on the analysis and findings from today's discussion.

VICE CHAIR LAMPKIN: Thanks, Jessica. I'm going to ask a couple of questions. I know I have about each -- one each for each of the recommendations. But first I want to say that this is really helpful evolution from our last conversation and I am particularly better appreciating, myself, the transition or the evolution from our prior recommendation to the Myers and Stauffer study, and the challenges that they found, and our restructuring and strengthening of that recommendation through a focus on demonstrations. I think that's a really nice path.

But I have a question about that recommendation, the demonstrations and best practices aspects of it, from the states' perspective. Do we know, either through the Myers and Stauffer study in the states we talked to, or any other conversations we've had for states, that states do have an appetite for these opportunities, better best practice dissemination from HHS, and option to participate

in demos? What's in it for the states? So that's my first question.

MS. MORRIS: I think -- we didn't post this question directly but we certainly heard from states that there's some informal sharing of information already, that they are seeking information on how to measure their own PI activities, that when they're interested in deciding on how to invest money they will perhaps check in with other states but they are aware, they are doing things. So there's -- I think it's all on an informal level right now and I think the appetite that we heard, that was more clear, was the desire to know what's working and what's not, to know how to measure whether it's working and to not feel that they always knew how to approach that.

VICE CHAIR LAMPKIN: And do we think that participation in demonstrations would give them authority to try things that they don't have the authority to try now, would provide them with technical assistance that they don't get now?

EXECUTIVE DIRECTOR SCHWARTZ: I guess part of this is to think about what they're actually experimenting and demonstrating, because it could be in the context of

something that they're already doing or something that's more about how you implement it, what data you collect. So it doesn't necessarily have to be something brand-spanking new that's never been tried before.

VICE CHAIR LAMPKIN: Okay. That's helpful. I just, as we ponder a recommendation for this, and particularly if we make the recommendation to Congress rather than the Secretary, it's helpful to think that there are states that would actually take this up. Right, so that was the source of that question.

And my question on the other one maybe is a little more technical. So the way we've structured the proposed recommendation number 2, about the RACs, is that we would make it optional. Would we actually be recommending that they remove the requirement that states do this, period, or would we be saying we want this to be -- the statute would say it was optional?

MS. MORRIS: So as it's written it's basically saying it would remove the requirement, and therefore states have the ability to opt into it. So it sort of takes that mandate out of the program.

VICE CHAIR LAMPKIN: Okay. Thanks. And then I

know Darin had a question, and then Kit, also.

COMMISSIONER GORDON: Yeah. Thank you for this, and I was looking back through the -- all the write-up on this to make sure I was seeing this correctly, and I can't say that I found it exactly. The RACs it was only applicable on the fee-for-service side, right? It was not a requirement on managed care. Is that correct?

MS. MORRIS: So the RAC program only applies to fee-for-service. Correct. They're not -- states are not required to require the MCOs to review encounter data, is the more direct answer to what I think you're asking.

COMMISSIONER GORDON: Also, our recommendation, in essence, is really more targeted, because I know it didn't prohibit states, because we did it in Tennessee, and we're 100 percent managed care. But our recommendation is, in essence, allowing those fee-for-service states to make a determination whether they build towards that. That's what recommendation 2 is basically getting at.

MS. MORRIS: Yes, and so I think -- I'm not sure what your question is but to add to what I think you're saying --

COMMISSIONER GORDON: It was just fee-for-service

-- it's really only limited to fee-for-service states where the obligation exists today, so now they, too, would only have -- they have an option to do it as states that managed care currently have an option.

MS. MORRIS: Yeah. So that's another way of putting it, correct.

COMMISSIONER GORDON: Thank you. I just wanted to make sure I --

VICE CHAIR LAMPKIN: Kit and then Penny.

COMMISSIONER GORTON: So going to proposed recommendation 1, and sort of building on what Stacey was talking about a couple of minutes ago, there's a lot of stuff going on now. Some that's useful, some that's not. That's a hypothesis.

So I think just in terms -- and I know we don't do meeting-based wordsmithing, but I think what we're looking to demonstrate is not necessarily new program integrity approaches but ways to evaluate program integrity approaches that give you some evidence that says this is valuable or it's not, in some way. Right? So because as I read this the first time it's sort of like, oh, well, you could sign up to do demonstration. Well, you know, if I'm

a state and I'm already doing -- you know, I already have a $5 million a year program integrity budget, I don't need a demonstration. What I need to know is what I'm doing work or not?

So it's really what we want them to look into is the program evaluation of the program integrity -- I mean, it's very hard to say, and so I'm not going to try and do it here. You're the English major, so --

COMMISSIONER GORTON: I see.

CHAIR THOMPSON: I don't think we would want to necessarily prohibit somebody, if they had a new thing, but the fact that it wasn't new doesn't mean that you couldn't come together with some other states, for example, and say we're all interested in looking at the effectiveness of our approach to utilization management.

COMMISSIONER GORTON: Right.

CHAIR THOMPSON: And, therefore, we want, I guess -- Alan isn't here to dispute whether that should be part of program integrity. But, you know, names name the thing --

COMMISSIONER GORTON: Provide the credentials.

CHAIR THOMPSON: -- right, and we may have

different ways of doing it, and we want to see is it more effective to do this or do that, or target this group of encounters or claims or that group of encounters or claims.

COMMISSIONER GORTON: And it might be useful to include an illustrative example or two, just to sort of give people the sense of that.

The second question I had is, is it our perspective right now that the Secretary currently has the story?

EXECUTIVE DIRECTOR SCHWARTZ: Yes.

COMMISSIONER GORTON: Yes. Okay. So then the point of view I would express is then I don't see any reason to bother Congress, and if the Secretary already has the authority then Congress other things to deal with and so perhaps we can provide the Secretary with some -- and just for everybody, right, well, we can provide this Secretary with some encouragement, because the Secretary who got the last set of recommendations is not this Secretary.

So maybe we can offer some ideas that provoke a little more activity on this part, you know, not casting it as a boil-the-ocean kind of thing or very expensive kind of

thing, but wouldn't it be useful, states have an appetite. You know, we might be able to frame it in such a way that the Secretary has -- you know, just to sort of restate, the Secretary has the authority and we would just like to reiterate the recommendation and suggest you use the authority this way.

CHAIR THOMPSON: So I'll try to be -- only focus on a few things. So one is, thank you. By the way, I'm not going to comment on the RAC recommendation. In my consulting practice I work with a company that does RAC work so I'm just staying away from that altogether.

So on this first recommendation, which I think is very responsive to our last conversation, and I agree with Stacey, it's a nice evolution and a way of not just repeating ourselves, which we could have just repeated our prior recommendation and kind of brought it back up. But I do think that we continue to see that there's a need for some things, and that need is about taking advantage of the natural experiments that are going on but putting more science around it and putting more rigor and discipline around it so that we really do figure out what's really paying off.

And the paying off, one point that I just want to make, Jess, is to make sure that we talk about it as both not just recoveries, which is easy to count, but also prevention, which is not so easy to count. And that when we talk about impacts that we take providers and beneficiaries into account, because there are program integrity approaches that can impose burdens, impose obligations on the part of providers and beneficiaries. Some of that may be justifiable. Some of that may be unnecessary barriers to provider participation or beneficiary participation, or access to care, et cetera, et cetera.

So I do think -- there was a place where you said no impact on beneficiaries. I do think these things ultimately end up impacting beneficiaries. Sometimes directly, because we ask beneficiaries to actually do something, or because we're doing something with providers and creating requirements for providers to go through different processes, and that may create delays for beneficiaries. I don't say that pejoratively. I'm just saying that's what happens and sometimes it's worthwhile and sometimes it's not, and sometimes there could be a

faster, better way, and sometimes there can't be.

So that's what we're trying, I think, to get at here, which is that if you're doing some of these activities, do it in a way that is the least burdensome and the most effective.

I do think, also, there's probably something to say here about the places where we think there is -- where the focus should be. So, you know, right now we just sort of say, you know, all program integrity. I think we should think about what we found in the Myers and Stauffer, like if there are some specific areas. I don't necessarily mean that we have to call out focus on these areas, but maybe we say something like we think particularly these areas deserve specific attention. You know, to the extent that we have some of those suggestions I think that would be very helpful.

I also think it's important, given what you said about the agency's current approach is one-on-one auditing support. I think we ought to emphasize, to me, the benefit of the federal government being involved here is multistate initiatives and information. So I think we ought to emphasize those places where groups of states want to get

together and look at something that they're doing. And, you know, the activity itself is probably -- could be supported through administrative funding or MAS funding, or maybe MIP funding. Some of what we're saying can be done here, is that we're supporting that with some information collection and research and evaluation and data collection and so forth.

So I do think that focusing it on areas where a number of states have interest would be a place to call out where to put some of this activity.

EXECUTIVE DIRECTOR SCHWARTZ: Yes, I just wanted to, sorry, back up a little bit and go back to Darin's question, because I think the gist of what Jess said is correct, but, in fact, all states have an obligation to do a RAC, and if they are 100 percent managed care, they have to get a waiver to cross the T's and dot the I's. And so -- if you made it optional, you wouldn't have to do a waiver, even if you never intended to do it.

COMMISSIONER CARTER: And they have a requirement to do the -- have a RAC, even if they have just a small part of their --

EXECUTIVE DIRECTOR SCHWARTZ: All states.

COMMISSIONER CARTER: -- program. All state requirements.

EXECUTIVE DIRECTOR SCHWARTZ: All states. I mean, I think in point of fact there's no expectation that 100 percent managed care, but there still is a hoop to be jumped through.

The real impact will be on the states the real impact will be on the states that are, feeling like they need to do this and then not succeeding in doing this, as opposed to, although all states would benefit from not even having to go through that paperwork exercise.

COMMISSIONER GORTON: And just for everyone's benefit, I mean, the thing that does get complicated in the managed care environment, which was complicated when we did it, is the plans are 100 percent risk and then you identify something, whose is it and when is it theirs? And so we had to come up with a gain after a certain period of time. But that's part of why it gets complicated in the managed care environment.

MS. MORRIS: Yeah, and to add a fine point to that, in the memo we point out that several of the states do have their waivers because of just a low number of fee-

for-service claims making the RAC program sort of not feasible. But a large number of them do have it because of just simple procurement issues.

VICE CHAIR LAMPKIN: Okay. Toby and Darin and Brian, then Bill.

COMMISSIONER DOUGLAS: I just wanted to echo Kit's points. In terms of recommendation 1, I really think it's important -- it gave me a little bit of pause to think about it as new demonstrations, that there's a lot of work already going on and it's more that it seems to be the focus of this recommendation needs to be around the -- that we need to get the tools to evaluate and allow states to come together to evaluate, rather than we're demonstrating something new, which came across a little like that.

CHAIR THOMPSON: Can I just ask, though, Toby, but you wouldn't object if they did. So say a bunch of states said let's get together --

COMMISSIONER DOUGLAS: Yeah, no. It's just --

CHAIR THOMPSON: -- we don't know value-based purchasing. What should our program integrity approaches be there? How can we, you know, develop that?

COMMISSIONER DOUGLAS: Absolutely. Yeah. It's

just changing the -- maybe it was just the -- it seemed like that was the focus.

COMMISSIONER GORDON: My comment was just something you had said, Penny. I kept wrestling with it in my head. I think I'm aligning myself with Kit, so it may get us out of this issue altogether on the first one. But if you look myopically at some of these things that may be multistate, and say was it effective in that state, and you abandon it, not recognizing that it is workable in other states -- it's just that I was thinking about, you know, the complexity of this and thinking about it not to narrowly, whenever there would be evaluating the success of these different programs. I think the bigger issue -- and Kit hit on it -- or Toby did -- we felt, in states, that there were just so many different activities and so many different folks at the federal level involved, we felt we weren't maximizing the limited resources we have and the time to target those things that are -- we may all agree are the highest value.

So, I mean, to some degree it gets to what I think you're trying to get at with recommendation 1, is really, okay, having some evidence of what are those

things. But I think the bigger is just the identification and the ability to allow we not to focus on the things that are of lesser return for our investment in time --

CHAIR THOMPSON: Right.

COMMISSIONER GORDON: -- and narrow the number of different meetings we had, that seemed like we talked about the same thing over and over again, just with different federal partners. So that's just a little added editorial comment.

CHAIR THOMPSON: Well, that's where I think having more evidence helps all of us, because then you can justify, I have resources that I'm devoting here, and the reason is when I'm looking at a risk framework and I'm looking at where I'm getting return on investment this is the place for me to go, right?

VICE CHAIR LAMPKIN: Brian and then Bill.

COMMISSIONER BURWELL: I guess my comments have to do with -- I mean, I actually think that this market is more advanced than even the Myers and Stauffer. I mean, like I work for a company that has a very active Medicaid program integrity business and there's lots of business to be had and it's a very competitive marketplace, and we bid

against other firms who are -- say their techniques are superior to ours. And I know my company is working very assiduously at using artificial intelligence and machine learning and all kinds of new technologies in this area.

So I am aligning myself with Kit. I'm not really sure what a federal demonstration would do beyond what states are already doing in this area. There may be need for more formal sharing of approaches, but you know and -- I mean, there's all kinds of conferences and tracks around program integrity programs. I'm not really sure what --

CHAIR THOMPSON: When you say -- I mean, Kit, were you suggesting that we should not -- I mean, it seemed like what we had clarified was this was not necessarily to engage in new projects but to actually produce evidence and information on a practical level about what works or doesn't work, apropos of our earlier findings, which say we don't have that information.

COMMISSIONER BURWELL: So not a demonstration of doing new program integrity approaches but more around --

CHAIR THOMPSON: I mean, if states want to, if they have some new things they aren't doing and they want to launch some projects and --

COMMISSIONER BURWELL: Collaborative approaches, right.

CHAIR THOMPSON: -- need -- right, and need some help to kind of say how is this going to work, yes. But also, importantly, we're doing -- we are investing a lot of resources. We need to know what is producing the greatest ROI and the greatest benefit, and the best methods by which to implement those approaches so that we're minimizing burdens on providers and beneficiaries.

COMMISSIONER GORTON: Well, and to Darin's point, everything you do there's an opportunity cost, right, because we can't do everything. So we do need to pick and choose. And, you know, limiting things like RAC from being mandatory so that you can focus on more useful activity.

COMMISSIONER SCANLON: Two reactions. One is this theme about the issue of new. I think we could solve that by taking established experiments and demonstration projects out of the recommendation and focus on the things that I would think are the most valuable, which is to identify what are effective program integrity approaches and disseminate that information. This is about learning, and there's all kinds of experience to learn from, and then

sharing information. And that's probably where we've failed today, is that has not been done.

VICE CHAIR LAMPKIN: So that takes us back, though, to our 2012 recommendation, which was --

COMMISSIONER SCANLON: I understand that, and I guess -- and that leads me to the second comment, which is -- and relates somewhat to Kit. My sense -- what he said earlier -- my sense is that every Secretary has got a list of shoulds that they are fully aware of and would acknowledge they are shoulds, and they do not have the resources to do them all. So the question is, how do we move this, if we believe it, up their list of priorities, to actually do something?

Now one way to do that is -- and this is, again, if we feel this strongly enough about this -- is to have the Congress tell them, this is a priority; we think you should be doing this. Okay.

Because again, the Department is stretched. There is no question about that. And so, I mean, you know, when you think about the original recommendation it came to the Department when they were doing the ACA. So do you think -- you know, would you have expected it to pop up to

the top of their priority list? I don't think so.

So that's what I -- I mean, I think the choice there, in my mind, is a question of how do you stress the priority that we feel about this, in terms of getting the message to the Secretary?

VICE CHAIR LAMPKIN: A question about that, though. Do you think that there is any vulnerability if we were to revert back to that similar language? What I would worry about, without really strong narrative -- and maybe that's the answer -- is -- but you tried to do this, MACPAC, and you came back and said it's hard, it's complicated, and you didn't have an answer. So, you know, where I thought the evolution to demonstration got, whether demonstration is the right word or not, was that it says, okay, you actually have to, instead of looking at something that's already happened and trying to draw your ROI conclusions from that, design something up front with that ROI calculation in mind. Start your evaluation before you start your initiative.

CHAIR THOMPSON: Well, to me it's not necessarily starting it beforehand but it does -- the idea of using language that does convey a certain kind of deliberate,

conscious rigor and development of the information, as opposed to like what we did, which is we went out and said, well, what have you got, and they said not much. And so it's like, okay, well, we need to invest in actually developing and producing the information that will put us in the position to evaluate it. So however we want to describe that, it seems to me that that's what we're really talking about is putting some frame around those kinds of activities and putting some resources behind the actual development of the information.

COMMISSIONER SCANLON: Right. It's not unprecedented in Washington to have recommendations repeated. I mean, and the issue is that sometimes they're repeated almost annually because there are circumstances where there's going to be an annual recommendation. And then there are windows in which some of those recommendations are adopted, so then you can feel really good.

So I guess I'm not too disturbed by the fact that this is very similar to what happened before. But what we're pointing out is it hasn't happened, and we think it's important.

CHAIR THOMPSON: Let me also say something on the Congress versus Secretary question that Bill just raised, just to pick up on that point because I struggled with that a little bit and I could kind of be convinced either way.

I did think that if we wanted to focus on Congress that maybe something to consider is whether or not we should also tell Congress that a portion of funding of the MIPS program should be set aside for this purpose. In other words, would it -- is there a value to kind of saying to Congress, we don't want you to just say to the Secretary you want to do it, but actually say, you know, 5 percent of the Medicaid Integrity Program funding should be devoted to this purpose and set aside for it, or something that, you know, creates some further incentivizing or structure around making sure that, you know, it actually happens. I don't have strong feelings about it. It's just a thought that occurred about if we wanted to devote it to Congress.

COMMISSIONER SCANLON: When you mentioned the word value-based, immediately CMMI also popped up in my mind. And the question, what's the relationship between this and the overall sort of program in terms of how we're transforming it and making sure at we incorporate integrity

considerations into that?

EXECUTIVE DIRECTOR SCHWARTZ: And theoretically, you could do a project through CMMI that was like this, just the way that CMMI funds the Innovation Accelerator Program.

VICE CHAIR LAMPKIN: So let's take a kind of quick pulse on where people are on this. We've talked a lot about recommendation 1, so maybe some wordsmithing around it, which the staff can take care of. But are folks generally thinking you we want to make a recommendation in this area related to reiterating what we said before, or strengthening it a little bit? Show of hands? Okay. Great.

Then with respect to the RAC one, the one thing I want to just throw out there, that we haven't had too much yet on, is -- so we talked about managed care and the challenges that that creates, and that states with a lot of managed care get waivers. States with procurement challenges tend to get waivers. We are saying it's effectively optional now because there are so many waivers. Just take the requirement out. But is an alternative to that saying, maybe to the Secretary, consider whether there

are ways that the RAC concept could be implemented in a way that would be more effective. Like is it still a good idea but states have just avoided the challenges of who gets to keep the recoveries, and the other challenges that managed care comes with? Actually bringing encounter-data in could be valuable. You could solve the procurement, you know, ask the Secretary to study it.

EXECUTIVE DIRECTOR SCHWARTZ: Couldn't that also be -- if the Commission were to adopt both recommendations, the discussion of the second recommendation could somehow refer back to the first?

VICE CHAIR LAMPKIN: Yep. Yep. That would --

EXECUTIVE DIRECTOR SCHWARTZ: I mean, this is a very clean recommendation. What you want to put in text around it is one thing. But I think that would be preferable to trying to jam it in there.

VICE CHAIR LAMPKIN: That's a great point. I hadn't thought about it that way but that makes a lot of sense.

And so kind of a quick straw poll on this one. Are most people feeling like they do want to move forward with this recommendation, staff brings back next meeting?

[Show of hands.]

VICE CHAIR LAMPKIN: Yeah. Okay. Excellent. Any other questions or comments, guidance for Jessica on this topic?

All right.

Oh, sure. Let's do that. Thank you. Any members of the audience like to come to the mic and make any comments on this topic for us?

PUBLIC COMMENT

* [No response.]

VICE CHAIR LAMPKIN: All right. Well, time to break. We'll be back at --

CHAIR THOMPSON: Yeah, we're running just a little bit behind so let's just come back in 10 minutes, at 3:05, and we'll pick back up with our last session of the day.

* [Recess.]

CHAIR THOMPSON: Okay. I'm going to give the one-minute warning for people to wrap up conversations before we get started again.

[Pause.]

CHAIR THOMPSON: Okay, Erin, you're going to take

us out today. We're ending with a great agenda item, talking about recovery support services. So let me hand it to you.

RECOVERY SUPPORT SERVICES FOR MEDICAID BENEFICIARIES WITH SUBSTANCE USE DISORDERS

* MS. McMULLEN: Thank you. So before I dive into our findings I just wanted to spend maybe a minute or two kind of reminding you all why we decided to take on this project.

So this time last year we were mapping out coverage of clinical substance use disorder treatment services in Medicaid programs in all 50 states and D.C., and that wound up being included in our June 2018 report to Congress.

At that time you also expressed interest in looking at recovery support services or those non-clinical services that include peer support or supportive housing, and try to identify the extent to which states are paying for that type of benefit.

So those services could be provided in conjunction with clinical treatment or outside of a medical model, to help support people's transition in the community

and through their process of recovery.

So when it comes to payment for recovery support for beneficiaries with an SUD it's relatively a new thing that state Medicaid programs are doing. It's been far more common in the past for states to pay for those types of services for beneficiaries with a mental health condition, but, you know, through this project we have seen that states do increasingly pay for recovery supports for beneficiaries with an SUD.

States are mainly using the state plan rehabilitative services option to pay for these services, but through the review of Section 1115 demonstrations we're also seeing states piloting different recovery support through that authority. We also found that states are paying for recovery supports through different payment methodologies, such as bundled payments to health homes, and then there's also a certified community behavioral health clinic demonstration that creates a prospective payment for certain community behavioral health providers in about eight states.

So now I'm going to take a moment to talk about our approach to this project. So to respond to your

interest in the coverage of these services we contracted with RTI International to compile coverage policies in all 50 states and D.C. So this project was conducted in two different phases. In the first phase we talked to 10 different subject matter experts to identify coverage of these services and try to figure out what Medicaid could pay for, for beneficiaries with an SUD. And then taking the results of these interviews we launched into the second phase of the project, which was to create a scheme to classify coverage of these different services.

So this assessment included looking at a number of different Medicaid authorities that are listed on this slide, and before I talk about our findings I do just want to thank our colleagues at RTI for their work on this project. In many ways, this was a more challenging undertaking than looking at coverage for clinical services. If you recall, we were able to use the American Society of Addiction Medicine, their levels of care, as a framework to look at coverage of clinical services. There really isn't the equivalent on the recovery support service side, so we really had to do -- RTI had to do a lot of work to kind of figure out how we wanted to classify these types of

benefits.

So the interview findings are included on this slide. We did talk to representatives from federal agencies, including SAMHSA and CMS, Medicaid managed care organizations, providers of recovery support services, and state Medicaid programs.

And we sought to answer a few different things through the interview process. One, we were trying to come up with some sort of definition to use for recovery support services. We wanted to capture how states were paying for the services currently, understand how states use non-Medicaid funding to complement coverage of these services, and then also try to identify any sort of challenges that states were facing.

So first we found there really was no consistent Medicaid definition for recovery support services. A lot of stakeholders we interviewed did cite the SAMHSA definition. But outside of some guidance that CMS has issued around peer support services there really is no Medicaid federal guidance on recovery support services writ large.

The second thing we found that was that when

Medicaid does pay for recovery support, states, you know, like other services, limit it to certain professionals for settings. We found a lot of stakeholders that we talked to mentioned the use of peers to deliver certain services. We also found that, you know, some states do limit this to just certain clinical settings, but by and large, states do allow payments for these types of services, both in clinical and then more community-based settings.

We also found that many recovery support services do rely on non-Medicaid funding. In part, this might reflect Medicaid's inability to pay for certain things, like room and board. We also found that some providers of recovery support might not be interested in, or have difficulty billing Medicaid. Some of the providers that we talked to stressed that their programs did not rely on a medical model and they were more a community-driven recovery support program. So for those types of providers, they felt that relying on grant funds or private funding may be a more appropriate way to deliver their services.

Another thing that we heard was that some providers, since they aren't traditionally a medical model, might just have difficulty having the infrastructure to

bill Medicaid.

So taking those interview findings, as well as conducting additional state-level research, RTI organized kind of our classification scheme of how to get recovery support services into the five categories listed on this slide.

So on the next slide we have the results from what they found. So as you can see, on the left side we have a description of the five different services. On the right we have, you know, how many states are actually paying for this benefit. I want to say that this is limited to services that are provided to adults, but we did find that states were more likely to pay for comprehensive community supports or peer support services than the other three services listed on this slide.

Generally, the comprehensive community support was limited to beneficiaries who had a more long-term, chronic substance use disorder or they had a higher level of functional impairment. We also found that those at risk of being homeless were also more likely to be able to receive or meet the eligibility standards to get comprehensive community support.

As you can see, peer support is the most frequently covered service. It can be paid for kind of through an individual basis or in group settings. Only a minority of states seem to limit this service to a more narrow population with an SUD. A lot of states pay for this through the state plan rehabilitative services option, and typically they offer a similar benefit to individuals with a mental health condition.

So the last three services on the table -- skills training and development, supported employment, and supportive housing -- are covered far less frequently, and generally they're only available to beneficiaries who do have a more chronic substance use disorder, and also have a greater level of functional impairment. We also have seen, in some of this data, that they are more likely to provide this service to people who would otherwise need an institutional level of care if it weren't for community supports.

And on the next slide, I'm just going to touch base really quick on the types of providers and types of settings these services are being provided in. We did find that state Medicaid programs pay a wide range of providers

to deliver these services, from peers all the way up to physicians. The providers of peer support services could include some sort of certified support specialist, certified family support specialist or recovery coaches. Often peers have a behavioral health condition and they obtain some sort of training that's required by the state, usually a certification, to be able to bill Medicaid.

According to SAMHSA, training generally includes a basic set of competencies such as personalizing peer support, supporting recovery planning, and then generally peers have to do some sort of continuing education.

We also found that generally states didn't limit treatment settings that recovery support services could be provided in. Often they listed clinical settings such as outpatient behavioral health clinics, and then community settings such as the beneficiary's home, as appropriate places to deliver and bill for these services.

We did find a minority of states did restrict it to only clinical settings, but I just want to emphasize that was a minority.

Another goal of this project was to determine whether states were complementing coverage of clinical

substance use disorder treatment with the provision of recovery support, and then how states were actually coordinating the provision of those services.

So often care coordination in the form of case management is used to ensure that there aren't gaps in services for people who are transitioning through different levels of care, and RTI was able to capture the coverage of three different types of case management services that are displayed on the next slide, so recovery management, transitional case management, and targeted case management. Again, we have the description of the service on the slide and the number of states that cover that service.

I do just want to stress that this table is inclusive of case management that is provided under a variety of different authorities. So in some states this benefit might only be available to people enrolled in a health home, or maybe leaving an IMD setting. It really depends on the state.

We did find that roughly half of the states that are paying for recovery management are doing it through an 1115 demonstration, while the remainder of states offer the services -- those types of services to people in health

homes.

Transitional case management is usually restricted to beneficiaries enrolled in a health home, again, but some states are providing it through Section 1115 demonstrations. And then targeted case management is more often than not paid for under the state plan, but it also could be bundled into a service for beneficiaries that are in those certified community behavioral health clinic demonstrations or health homes.

So we spent a lot of time, this time last year, talking about how states were using those Section 1115 demonstrations to expand access to clinical care, but we also wanted to take a minute to highlight how states are using them to also expand access to recovery support services, but then also to pay for some sort of case management services.

So we picked two examples for you here, with Illinois and Massachusetts. You know, Illinois is offering a number of pilot programs under their 1115 demonstration, and Massachusetts has added some recovery support services in addition to getting that waiver from the IMD exclusion.

I do want to stress, though, that several states

are doing this. It's not just these two. We found, I think, at least five states that were paying for some sort of a peer support under their Section 1115 demonstration, and we also found at least five states that were paying for some sort of case management service.

So again, I think this just as reinforced our findings from last June that states are really using these demonstrations to kind of take a comprehensive look at what their substance use delivery system needs.

So looking forward, you know, we did find that a lot of states are paying for peer support, but very few are paying for those supported employment or supportive housing services for beneficiaries with a SUD. Part of that might have to do with a limited amount of federal guidance that is substance use specific. The SUPPORT for Patients and Communities Act that passed this past October -- oh, sorry -- that was signed into law in October, does require CMS to issue some additional reports and guidance this year to states, mainly around supportive housing for beneficiaries with a SUD. It also requires them to do some technical assistance.

We're going to continue to monitor the

developments of 1115 demonstrations, just to see what sort of progress states are making and how they're evaluating the coverage of these services. And we'll be taking the findings from this project that RTI did for us and put them into an issue brief that provides a little bit more granular detail on the types of services that are being covered, the populations they're being offered to, and the authority states are using.

So that concludes our work on this project and I'm happy to take any questions you have.

CHAIR THOMPSON: Thank you, Erin. I think this is terrific work and I really think it's very responsive to the questions that we had asked you about where this fits in the continuum of care and what states are really doing.

Peter, do you want to kick us off?

COMMISSIONER SZILAGYI: Yeah. Just a quick question. This was really great. Very good descriptive information.

I know most of these are on waivers. Are there any preliminary data that's beyond descriptive on any kind of outcomes on homelessness, you know, hospitalizations, ED visits, anything like that, you know, sort of interim

analyses?

MS. McMULLEN: Yeah. On the substance use waivers, yeah. So we -- I think in the June chapter we included the initial finding that Virginia had. They did see a decrease in ED use, an increase in MAT, and increased access to services. I think the challenging part is when states are evaluating these programs is that they're not doing one thing with the waiver. You know, I think Virginia, in addition to, you know, adding new services, they increased their payment rates. I think I might be confusing my states but I think they also carved a behavioral health benefit into managed care around the same time.

So I think it's hard to, you know, isolate the impact of maybe just one of these interventions, and states are doing so much. We are kind of monitoring to see when those interim evaluations and data are submitted to CMS, but there's not -- you know, there's not a ton of information right now that we can share.

CHAIR THOMPSON: Kit.

COMMISSIONER GORTON: So you talked about a lot of states doing a lot of different things. Is everybody

doing something, or is there a subset of states out there who are not doing anything at all? You know, I think when you do the issue brief it might be useful to, in some kind of figure, do a distribution of, you know, where is there a lot going on and clearly places like Illinois, a lot going on, and, you know, are there deserts, for lack of a better term. Do you have a sense of that today?

MS. McMULLEN: Yeah. So, interestingly enough, some states that have more limited coverage of clinical services actually do pay for more recovery supports. So I -- you know, that's not all states but there were some states where we found that.

You know, a lot of states that are pursuing the waivers are covering a more broad array. They're also probably potentially in a better position to kind of seek these additional pilots and that sort of thing, because they're thinking about it and they're dedicating more resources to it.

You know, I think what makes this a complicated issue is that these services, since they are less well defined, can be covered under so many different authorities, and states that are paying for these as under

kind of more home- and community-based authorities, you know, it's hard to say how many people are actually getting those services. That's not something that we, you know, looked at under this project.

COMMISSIONER GORTON: So I think for future work, at least, in terms of access to the services, I mean, to the extent that over time we can develop some sense of the geographic distribution of access to these and the readiness of access -- do you have to be in a major city in order to access these in a given state, or can people in rural communities, frontier communities somehow access these kind of things? I think, again, not for this round but I do think that that's a thread that's worth continuing to pull on.

And I guess the other -- my thought is if there are states that are not doing something, I'm not sure what the justification would be for states that are not doing anything, but it would be worth asking them, or states that aren't doing much, what are the barriers? What are the limitations? What can't you do? Do you have something in your medical practice act or something else that's getting in the way of doing this, or do you need technical support,

or that sort of thing?

We have a tendency to focus on the above-average -- it's sort of a Lake Wobegon effect, right. We're always looking at the best performer but I think from time to time it's useful to ask the lagging folks why it is that they're lagging. I'm sure it's not due to bad intent, but we ought to figure out what the barriers are and see if we can address them.

CHAIR THOMPSON: Well, and along those lines I was wondering whether or not -- I mean, are there like legitimate concerns that people have about some of these services, about the clinical evidence for them, about -- we talked earlier today about program integrity. You know, are people concerned about some of those kinds of issues as they think about tackling this, or is it purely a matter of the health care delivery system capacity and cost?

MS. McMULLEN: Yeah, and I will say that in states where Medicaid isn't paying for these services it does seem like states are using other funding streams to provide these types of services to Medicaid beneficiaries. So I think just because a state is not paying for a service doesn't mean that they haven't come up with other avenues

or pathways to try to make that service available.

CHAIR THOMPSON: Any other -- oh, Martha.

COMMISSIONER CARTER: I've been sitting here thinking about how this intersects with Neonatal Abstinence Syndrome. I know I'm aware, in West Virginia, of a project, Drug-Free Moms and Babies Project, where they're using peer support and intensive case management for women with substance use disorder to help them through the pregnancy so they're not lost to follow-up, and so they have assistance with their babies afterwards. Obviously they're going to be born addicted to some substance.

So, you know, probably this is future work, but just how states are handling the whole range of NAS care and prevention, if you will, or best outcomes that are possible under those circumstances. I don't see that the Commission has done a lot of work on NAS. I mean, there are some really innovative things going on in hospitals, outside of hospitals, setting up special places to take care of babies that are born addicted, that aren't in hospital settings, for example. Not using medication management but using Mom as the first line of therapy.

So there's lots of interesting stuff going on and

I'm not sure where we look at that, but, you know, what's out there and what are the states doing to support those innovations.

MS. McMULLEN: Yeah, we did capture some of that through this project. That level of granularity obviously doesn't come through in what we presented today. But I do think there's probably -- we can leverage the work that RTI did for us just to maybe kind of tease out how certain special populations are getting these types of services.

CHAIR THOMPSON: Okay. Any other commentary from the Commissioners, or questions?

[No response.]

CHAIR THOMPSON: Any from the public on this subject?

PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: Thank you, Erin, and thanks to the RTI team. This was a challenging, I know, project, because of the fact that you have to go sort of define the question in various ways and then go to a lot of different data sources to pull it all together. So thanks to you and the RTI staff for this work. I think it will be very

useful for people to have.

Okay. Any final comments or questions from the Commissioners before we adjourn for the day, or from the public?

PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: Okay. See you tomorrow. We are adjourned. Thank you.

* [Whereupon, at 3:32 p.m., the meeting was recessed, to reconvene at 9:30 a.m. on Friday, March 8, 2019.]

PUBLIC MEETING

Reserve Officers Association
Top of the Hill Banquet and Conference Center
One Constitution Avenue NE
Washington, D.C. 20002

Friday, March 8, 2019
9:36 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
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AGENDA PAGE

P R O C E E D I N G S

[9:35 a.m.]

CHAIR THOMPSON: Welcome, everyone.

Kate, we are glad to see you kick us off this morning talking about eligibility groups.

RESPONDING TO SUPPORT ACT REQUIREMENT: ELIGIBILITY GROUPS FOR HHS DATABOOK ON MEDICAID AND SUBSTANCE USE DISORDER

* MS. KIRCHGRABER: Sure.

Good morning. In this session, we're going to discuss the report requirement and the SUPPORT for Patients and Communities Act, also known as the SUPPORT Act and formerly known as the opioids bill.

Section 1015 of the SUPPORT Act requires the Secretary of Health and Human Services to publish a substance use disorder data book report using T-MSIS data. The report will provide comprehensive data on the prevalence of substance use disorders in the Medicaid population and the services provided under Medicaid for the treatment of those disorders.

Among other data, the report must include the number and percentage of individuals in each of the major

Medicaid enrollment categories who have been diagnosed with a substance use disorder and whether those individuals are enrolled under a Medicaid state plan or a waiver.

The report is due this October, and HHS is required to issue annual updates by January 1st each year through 2024.

The SUPPORT Act also charges MACPAC with defining in a public letter to the HHS Secretary the major Medicaid enrollment categories for purposes of this report. MACPAC's role in the report is limited to sending the public letter, defining the major enrollment categories, and the statute does not require the Commission to send the letter by a specific date. And you have in your materials the draft letter.

So the draft letter includes the eight eligibility categories you see here. So it's children; adults split between the new adult group and other adults, such as parents and caretaker relatives; individuals over age 65; people with disabilities, again, split between adults and children; pregnant women; and individuals who are dually eligible for Medicaid and Medicare who receive full Medicaid benefits.

These categories are consistent with the eligibility breakouts that we use in our MACStats data book and with what we expect to be available through T-MSIS.

We're asking for these breakouts for a number of reasons; for example, separating the new adult group from other adults to help us capture parents who are covered by Medicaid but not in expansion states. And eligibility groups like children and individuals with disabilities tend to have different use patterns.

We'd like to include full-benefit dual eligibles to capture the population that Medicaid pays for and to pick up the dually eligible beneficiaries under age 65.

We consulted with CMS staff when we initially developed this list, and it was mostly consistent with their thinking. They let us know this week that they have some lingering concern about data quality and probably would prefer to report on fewer groups and have suggested they could possibly do fuller breakouts in later reports.

We also included sort of a wish list if the T-MSIS data is available of special populations that were particularly affected by the opioid epidemic. So those would include children who qualify for Medicaid on the

basis of child welfare assistance, who generally have a high prevalence of behavioral health conditions; full-benefit dually eligible beneficiaries under age 65 because they experience a higher rate, again, of behavioral health conditions; and beneficiaries over age 65. Older adolescents, age 16 and 17, could be prescribed buprenorphine, so we think that that's a useful population to pick up. And, lastly, recognizing that Medicaid plays a critical role in the care of infants with neonatal abstinence syndrome, we think it could be useful to get data on this group. Although it's not characterized as substance use disorder, it results from exposure to opioids and affects thousands of infants whose care is paid for by Medicaid.

So for the next steps, it would be helpful to get the Commissioners' thoughts on the draft letter. So I'll open it up to you guys.

CHAIR THOMPSON: I'll just say I think the letter is fine. I think the categories that you've proposed are reasonable.

Just responding to your point about T-MSIS maturity, I don't think it's something that we have to say

in the letter. I mean, we can all acknowledge that there may be a particular concern or issue about data in a particular state or data with a particular population. I think it's appropriate for our letter to give our best advice about what we think is the most meaningful data to produce and recognize that there may be some practical issues that could occur here and there, and CMS will, of course, have to respond to that or have to provide whatever asterisks they need on whatever data elements that they think may not be complete, for example.

But I think it's better to leave that in their hands and let them handle that, as appropriate, based upon their deeper knowledge of the dataset and where there might be some shortcomings or not and have our letter focused on what we think are the appropriate categories to be aiming to report on.

And I agree that adding the additional ideas about some subpopulations in particular that might be worthy of some specific attention is also a useful thing to do for the agency.

Do other Commissioners have any comments or questions?

VICE CHAIR LAMPKIN: I'll just briefly say from an actuarial perspective that this set of groupings makes a lot of sense. It's very consistent with where we see patterns of variation as we've been working with our clients on OUD treatment and those sorts of things, so it looks good to me.

CHAIR THOMPSON: Peter and then Darin.

COMMISSIONER SZILAGYI: Just a very brief comment. I agree with the letter. I agree with the special populations. Older adolescents is easy because that's based on age, and yes, it won't be perfect. But I think this is an example of where perfect shouldn't be the enemy of good, and it is an important population. Children are hospitalized for a very long time sometimes for NAS, and it's worth getting some data, even though it won't be perfect.

COMMISSIONER GORDON: I like the letter as well. I think as we talk about NAS, some of the groupings that we have really don't isolate the pregnant mothers, and I think if we're going to be talking about NAS, someone who is pregnant with the diagnosis, I think would be relevant. So I don't know if there's some commentary to put there.

I know it's typically broken out for managed care rates, but I don't know if it is for others, that category, but it's just something that I think would be additive, particularly as we're thinking about NAS.

MS. KIRCHGRABER: So pregnant women with NAS. Okay.

COMMISSIONER GORDON: Well, pregnant women with an SUD diagnosis.

MS. KIRCHGRABER: With an SUD. Right, right.

CHAIR THOMPSON: So we do have pregnant women laid out in the category.

COMMISSIONER GORDON: Okay. I'm sorry. I read right past that one. Thank you.

CHAIR THOMPSON: Yeah. I think we've covered that, but I'm glad that you're emphasizing the importance of that because I think that is something --

COMMISSIONER GORDON: Because I think it just struck me as a special population. I read right past that one. Sorry. Thank you.

CHAIR THOMPSON: Right. Versus the --

MS. KIRCHGRABER: Yeah. It was on this list.

And T-MSIS will have a flag for pregnant women,

which is progress over MSIS.

CHAIR THOMPSON: Okay.

COMMISSIONER GORTON: Does T-MSIS have a flag for children in substitute care?

MS. KIRCHGRABER: I'm not -- we can check. I don't know.

COMMISSIONER GORTON: There was commentary yesterday about the substance use being particularly challenging for children in substitute care. The letter is fine, and for this year, that's what they should do. As we talk about wish lists for special populations, if going forward we could think about methodologies that either we could use or that CMS could use to shed some more light on what's happening in substitute care, that might be useful.

CHAIR THOMPSON: Do we want to -- do you want to check on whether T-MSIS has that kind of flag, or do you want to just check on maybe adding a sentence that say something about we'd like to --

MS. KIRCHGRABER: It looks like there at least a flag for children who have IV-E adoption assistance.

COMMISSIONER GORTON: Yeah. So like Peter said, not perfect, but perhaps worth exploring, and maybe in

this, you know --

CHAIR THOMPSON: Yeah. No, that's what we're here to discuss. If we want to add that as a call-out in that last paragraph --

EXECUTIVE DIRECTOR SCHWARTZ: But that's here.

CHAIR THOMPSON: Is it already here?

EXECUTIVE DIRECTOR SCHWARTZ: Children who qualify for Medicaid on the basis of child welfare assistance. It's that.

CHAIR THOMPSON: Okay.

COMMISSIONER GORTON: Oh, okay. Perfect.

CHAIR THOMPSON: Okay. Good, good. Okay.

Any other questions or comments?

[No response.]

CHAIR THOMPSON: Great. So we can pen that letter and get it out and look forward to seeing those data.

Thank you, Kate.

VICE CHAIR LAMPKIN: All right. Next up, we've got Chris with proposed rule on safe harbor protection for drug rebates.

REVIEW OF PROPOSED RULE AFFECTING SAFE HARBORS FOR PRESCRIPTION DRUG REBATES

* MR. PARK: Thank you.

Today, I'll provide an overview of the proposed rule that the Department of Health and Human Services Office of Inspector General released on February 6th regarding the drug rebate safe harbor.

I'll go through a quick background on the anti-kickback statute and discount safe harbor as well as information on Medicaid and Medicare drug rebates and coverage.

Then I'll summarize the provisions of the proposed rule and the actuarial analysis that HHS had commissioned and included with the proposed rule.

Finally, I'll highlight a few potential areas on which the Commission may want to comment. As a reminder, statutory authority invites but does not require the Commission to comment on proposed rules. Should the Commission decide to comment, staff will prepare a letter reflecting discussion today at the meeting. Comments are due April 8th of this year, prior to the April Commission meeting.

The federal anti-kickback statute is intended to reduce fraud, waste, and abuse by prohibiting transactions designed to induce or reward referrals for items and services covered by a federal health care program, such as Medicare and Medicaid.

The HHS Office of Inspector General has been tasked with implementing safe harbors for certain commercial transactions that offer discounts or reductions in price. These include, for example, discounts that are clearly disclosed and accounted for in a Medicare or Medicaid claim.

In 1999, OIG provided a definition for rebates that would qualify drug rebates as acceptable discounts, and so they are currently protected under this discount safe harbor.

Under the Medicaid Drug Rebate Program, Medicaid receives rebates defined in statute. In exchange, the program must cover all of a manufacturer's drugs. These rebates include two components. There is the basic rebate, which is for brand drugs, the greater of 23.1 percent of average manufacturer price or average manufacturer price minus best price. And there's also an additional rebate if

price increases faster than inflation.

States can also negotiate supplemental rebates with manufacturers. Manufacturers generally provide these rebates in exchange for preferred status on the state's preferred drug list.

And states with the prescription drug benefit carved into managed care, the MCOs can also negotiate their own rebates with manufacturers in exchange for preferred status. States and MCOs may contract with pharmacy benefits manager, or PBMs, to negotiate these rebates.

Under Medicare Part D, there are no statutory rebates. Part D plans can negotiate rebates with manufacturers, similar to managed care plans for preferred status on the formularies, and these plans may also use PBMs and negotiate those rebates.

Medicare beneficiaries may have cost sharing that is tied to the cost of the drug. For example, when a beneficiary is in a deductible phase or has coinsurance that is determined on some percentage of the drug's price, this percentage is determined on the list price as well as if they're in a deductible phase. The price the beneficiary has to pay is based on the list price and not

the net price after rebates.

There is concern that the current rebate structure can create incentives for the manufacturer to raise list prices and for health plans and PBMs to shift a greater share of the expense to the beneficiary.

Under this rule, HHS is trying to change the rebate structure so that the beneficiary's cost sharing is based on the discounted price.

The proposed rule would eliminate protection for the existing rebates that manufacturers provide to Medicare Part D and Medicaid MCOs, including PBMs acting under contract with these plans.

Because the anti-kickback statute and discount safe harbor only apply to federal health care programs, the current rebates would still be allowed for other payers, such as commercial plans.

This change would not apply to rebates required under law, such as the Medicaid Drug Rebate Program. HHS also does not believe that the state supplemental rebates would be affected. This provision would go into effect January 1st, 2020.

The proposed rule would create a new safe harbor

for manufacturer discounts given at the point of sale under certain conditions. They would have to be fixed and disclosed in writing in advance of the sale. They cannot involve a rebate unless the full value of the reduction is provided to the dispensing pharmacy through a chargeback, which is a payment made directly or indirectly by the manufacturer to the pharmacy, so that is a total payment to the pharmacy, that is, the plan payment beneficiary cost sharing, and chargeback for the drug is at least equal to the price agreed upon by the manufacturer and the Medicare Part D or Medicaid MCO plan. And the discount would be completely reflected in the price the pharmacy charges the beneficiary. This new safe harbor would go into effect 60 days after the publication of the final rule.

The proposed rule would also create a safe harbor for certain manufacturer payments to PBMs for services that the PBM provides a manufacturer, such as identifying 340B claims to prevent duplicate discounts under Medicaid.

These payments would be covered in a written agreement, and the payments must be consistent with the fair market value, be a fixed payment not based on a percentage of sales, and not take into account the volume

or value of any referrals between a manufacturer and the PBM's Medicare or Medicaid plans.

As part of the regulatory impact analysis, HHS included three actuarial analyses they had commissioned from the CMS Office of the Actuary, Milliman, and Wakely Consulting Group. The primary focus of this proposed rule is on Medicare, and as such, these analyses were primarily focused on Medicare Part D premiums, cost sharing, and federal spending.

I don't go into these Medicare estimates during this presentation.

Only the Office of the Actuary estimated the potential effects on Medicaid. Milliman did include a discussion of the potential effects but did not attempt to quantify those effects.

The proposed rule's effect on Medicaid is primarily driven by the manufacturer response. Under this proposed rule, manufacturers could convert their existing rebates to the point-of-sale discounts, or they could lower list prices.

Manufacturers may seek to recoup some of the existing rebates and raise net prices because the post-of-

sale discounts would not drive market share to the same degree as the rebates to plans and lowering list prices would be applicable to all payers.

There was great uncertainty among the three actuarial analyses on how manufacturers would respond, how they would convert rebates to either point-of-sale discounts or lower list prices.

This uncertainty led to a wide range of effects, depending on the assumptions chosen, both in magnitude and direction. Some scenarios would lower overall federal spending while others would increase federal spending.

The elimination of the safe harbor for Medicaid MCO rebates may not have much of an effect. The shift from plan rebates to point-of-sale discounts is not particularly relevant to Medicaid, as beneficiary cost sharing is nominal.

If the plan loses rebate dollars, the capitation rates would increase correspondingly to reflect that the plan's net drug costs have increased.

States could offset some of these capitation rate increases by including the managed care enrollees in their own supplemental rebate negotiations. Nineteen states

currently negotiate state supplemental rebates that include managed care utilization. States could also carve out the prescription drug benefit from managed care contracts. While states may be able to offset the increase in capitation rates with new supplemental rebates, both plans and states generally prefer to have drugs carved in, as this provides a plan with more information to better manage care. And many states prefer to keep the plans at risk for managing the benefit.

The greatest behavior response for manufacturers will be on the Medicare program -- and these actions could affect Medicaid rebates. Switching to point-of-sale discounts would not affect Medicaid best price, as Medicare Part D prices are excluded from best price.

Point-of-sale discounts could affect Medicaid rebates due to some uncertainty to how pharmacy chargebacks would be handled in the calculation of average manufacturer price.

If the manufacturer decides to lower list prices instead, then Medicaid's payments to the pharmacy would decrease due to lower list prices. However, the lower list price would also lead to a lower average manufacturer

price, and that would lead to a decrease in the statutory rebates, particularly reductions in the inflationary component of the rebates.

The decrease in statutory rebates may exceed a decrease in pharmacy payments, leading to an increase in net Medicaid drug spending.

This is an illustrative example that Milliman included in their actuarial analysis showing the effect of lowering list prices that I just described. In this example, the brand's unit price was $1 when it launched but increased over time to $1.47. The basic rebate here is assumed to be the 23.1 percent of average manufacturer price, so the 34 cents, and then there is additional inflationary rebate of 31 cents.

So, in the next column, if the list price was lowered by 15 percent, the basic rebate component is also 15 percent lower, but the inflationary rebate, as you can see, is significantly lower. It would only be 9 cents in this scenario.

This results in a decrease in the rebates of more than 40 percent, which more than outweigh the savings in list price. Net price of the drug increases by 7 percent

in this example.

This table shows the Office of the Actuary's estimate on the effect of Medicaid over 10 years from calendar years 2020 to 2029. Based on OACT's assumptions, the proposed rule would result in an effective average decrease of approximately 3.2 percent in the average brand price reported to the Medicaid drug program, as well as future drug price decreases. So the price reductions would lead to $18 billion in savings.

These savings would be offset by the reduction in the statutory rebates and lower drug price inflationary rebates. The Office of the Actuary estimated that drug rebates would decrease $18.5 billion. So that would be a cost to the Medicaid program of $18.5 billion.

They also estimated a slight increase in capitation payments as well for a net increase of $1.7 billion in federal spending and $0.2 billion in state spending, a total of $1.9 billion in increased Medicaid costs.

HHS has requested comments on several topics related to the effect on Medicaid statutory and supplemental rebates, capitation rates, and beneficiary

access. These questions suggest that there is significant uncertainty on how this proposed rule would affect Medicaid. The focus of the proposed rule is not particularly relevant to Medicaid, and the effects generally depend on the manufacturer's behavioral response to these changes.

As shown in the commissioned actuarial analyses, manufacturers' actions are hard to predict, and different assumptions can lead to a wide range of estimates.

The Commission may want to express concern in proceeding with this proposed rule, while there is significant uncertainty on the effect of Medicaid, particularly when the Office of the Actuary has estimated an increase in Medicaid spending.

The Commission may also want to comment on supplemental rebates. HHS believes that state supplemental rebates are not affected by this proposed rule; however, they are soliciting comments on the extent, if any, to which supplemental rebates may be affected by this proposal, suggesting that the protection of supplemental rebates may not be definitive. Supplemental rebates are not explicitly defined in statute, so the Commission may

want to comment that HHS should include specific language that would protect supplemental rebates under the safe harbor.

Also, HHS has stated that while this proposed rule would not alter the regulations and guidance to implement the Medicaid Drug Rebate Program, the Department may issue separate guidance if this proposal is finalized to clarify the treatment of pharmacy chargebacks and the calculation of average manufacturer price and best price.

The Commission may want to comment on the importance of these clarifications due to their potential impact on the amount of rebates Medicaid receives, and that this guidance should be in place before the safe harbor rule goes into effect to ensure that Medicaid receives the appropriate rebates.

With that, I will stop and turn it over to the Commission for any questions.

VICE CHAIR LAMPKIN: Thanks, Chris.

These new safe harbor parameters wouldn't apply to commercial products or qualified health plans on the exchange; is that right?

MR. PARK: That's correct. Based on what they've

stated in the propose rule, these should not apply to any programs outside of Medicaid and Medicare plans.

VICE CHAIR LAMPKIN: Do we know why they included Medicaid MCOs in this without that beneficiary aspect that applies on the Part D side? Is there a need to include Medicaid MCOs in this rule?

MR. PARK: We are not sure as to what HHS has the authority to change within the safe harbor, but we could comment that we think that Medicaid like supplemental rebates or Medicaid MCOs should be exclusively protected under the safe harbor if you feel that's appropriate.

VICE CHAIR LAMPKIN: Well, I mean, from the OACT analysis, clearly that's not the main driver over the increase, potential to increase, Medicaid spending is the Medicaid MCO piece, but it does add something to it. So I was just curious about whether that was something that was subject to a different decision.

MR. PARK: Yeah. We're not sure as to what authority HHS would have to separate out Medicaid versus Medicare.

VICE CHAIR LAMPKIN: Okay. Bill, do you want to start us? Then Toby and then Alan.

COMMISSIONER SCANLON: Chris, thanks very much. This is clearly a hot topic these days in terms of drug pricing, and this is a really good summary of this aspect of the issue.

I guess what was underscored for me and reading what you provided us was the great uncertainties that exist, and at this point, at least operating off of the actuary estimates, the relatively limited impact on Medicaid in terms of -- there's some significant distributional changes that would go on, but in terms of the net dollars changes for the states in particular -- I think the estimate was $2 billion over 10 years.

MR. PARK: 0.2.

COMMISSIONER SCANLON: $0.2 billion over 10 years, so even a smaller number. So, on an annual basis, we're dealing in the millions.

I guess for me, sort of this idea of us commenting, there's a number of things that I think we would need to have some answers to. One is, what's the level of uncertainty? I mean, are we talking about if we go from 0.2 to 0.4, that's one potential. I mean, that's doubling, but the question is we're still talking fractions

of billions.

The second sort of question would be, what do we feel the actuary may have left out in terms of elements of their analysis that we would consider is important?

And then I guess the third one, because as you've talked about -- the major impact here is on Medicare and Medicare beneficiaries, and I think that we really would need to be sensitive to that because the issue today is that one of the things that's been happening is that rebates are not benefitting the people that are using the drugs. They're benefitting more the entire sort of set of enrollees in a plan because the rebates will reflect the net that the plan pays on total, not necessarily what's being paid at the pharmacy counter, and the net result is that a lot of people save on premiums, but people that end up sort of being sick and needing these drugs are paying more.

MedPAC has talked about this. For that reason and other reasons, we've got many more people moving through the doughnut hole to the catastrophic phase, which is having an impact as well.

My sense is that one of the other things I'd like

to think about if we were to say -- I mean, as you suggested, do we need greater certainty? Well, are there remedies to try and protect the Medicare stake in this as well as not -- reduce the uncertainty and be sure that the Medicaid impact is as low as we've gotten.

Okay. Thank you.

VICE CHAIR LAMPKIN: Toby, Alan, Melanie, and Darin.

COMMISSIONER DOUGLAS: Chris, I just have a question to understand the interaction with the discussion yesterday on eliminating or increasing these projections and how that would change those projections.

MR. PARK: In terms of if we raise the rebate cap?

COMMISSIONER DOUGLAS: Yeah.

MR. PARK: I would assume that because the rebate cap would allow the inflationary rebate to go further, if we took the rebate cap off, then it would be a larger decrease in the rebate. Potentially, in a world where the rebate cap didn't exist, this would have a greater effect on Medicaid.

COMMISSIONER DOUGLAS: So meaning those

projections from CBO would be a lot lower?

MR. PARK: I would have to think about how that would play out, but yeah. I'm not sure exactly how that would necessarily affect those projections of CBO.

COMMISSIONER DOUGLAS: Okay.

COMMISSIONER WEIL: Chris, this is very useful.

In general, I want to say I agree with Bill that we need to be careful not to overstep how much we know this is not primarily targeted at Medicaid.

But it does seem to me -- and it would help me if you could help me understand if I'm getting this right. The big uncertainty has to do with this sort of oddity of the lever around the inflationary rebate. Basically, we've got -- the theory of the overall change is to pull dollars out of rebates and get them back into prices, which would lose prices, but it doesn't really lower prices. It lowers the way they're counted in rebate, but it just takes the negotiated rebate out.

Would it be possible -- I certainly don't know the technical answer to this, but would it be possible to basically say there needs to be some additional examination of potentially rebasing the inflation rebate? Because you

have a discontinuity in the pricing mechanism. So I don't know technically how you'd figure that out, but it just seems like price means something different, so inflation means something different.

So if we just thought about inflation not as continuous from release, but there's now been this discontinuity that changes the pricing structure, if we could figure out how to do that, I think states would be held harmless, and a lot of the uncertainty would go away.

VICE CHAIR LAMPKIN: Melanie and then Darin.

CHAIR THOMPSON: That would be statutory, right?

COMMISSIONER WEIL: I'm not -- ask him.

[Laughter.]

CHAIR THOMPSON: Would that be statutory, Chris? Because I think that's a really interesting proposition.

MR. PARK: I think that would have to be statutory because certain components of like the inflationary rebate in terms of what prices they're using and like where the baseline is and how it's calculated.

Particularly with the calculation of AMP, I think there would probably have to be statutory clarification for the inflationary rebate that the AMP maybe would be

adjusted somehow going forward.

CHAIR THOMPSON: Which is not to say that we couldn't find a way to describe what we think is going to happen, but just to understand that part of it.

COMMISSIONER BELLA: Yeah. I'm thinking of this differently, which means I probably don't -- there's some big piece I'm missing. But like in my head, I'm just kind of calling the question on why is Medicaid even in this. If the point is to get money to Medicare beneficiaries, the situation is quite different here. It seems to me the easiest thing is to say take Medicaid out.

So we're talking about a lot of like analysis and assumptions and this and that, and we're kind of overcomplicating I think a core question about what are you trying to achieve by putting Medicaid in there. Arguably, it kind of reminds me of the public charge discussion where it was like let's just shine a light on perhaps you didn't fully think about kind of how it would or would not impact Medicaid, and maybe you don't need to have it in there in that way.

So I guess I'm not understanding why we're having a discussion about all these things we might try to analyze

or whether it's a lot of money or a little money. I'm trying to understand if the core thing is about Medicare, let it be about Medicare and just like perhaps they made a mistake or didn't fully think through like why they put these in here.

It goes back to Stacey's point about why would they even be in here.

VICE CHAIR LAMPKIN: Right. So I think that's a question that goes to the 1.3 on this table of whether this is applied to the Medicaid MCOs and the implications there, but that doesn't affect the best price and the rebate calculation.

I mean, you could exclude Medicaid MCOs, and you'd still have this dynamic on the pricing that influences the 18.5.

MR. PARK: That's right.

VICE CHAIR LAMPKIN: As I understand it.

MR. PARK: That's correct.

To the extent that they change pricing for the Medicare plans, it wouldn't affect best price, but as Alan pointed out, the greatest effect is on this inflationary component, if manufacturers choose to lower list price.

Because the inflationary component as shown in this Milliman example can be decreased significantly if they lowered the list price, that's where the greatest effect to Medicaid rebates are.

COMMISSIONER BELLA: This goes back to what you were trying to understand, then, could we address this with some other action on --

COMMISSIONER DOUGLAS: Well, I was trying to understand the interaction, but I think Alan is kind of getting -- that's what Alan -- I mean, it kind of gets to then the other proposal, which would take statutory --

MR. PARK: Yes, certainly.

If the inflationary rebate goes down, then drugs are less likely to hit that rebate cap.

COMMISSIONER GORDON: So I appreciate Alan artfully describing what I'm challenged with here because there's a -- and then to Melanie's point, so why if the policy objective is really trying to address getting some of the benefit to the beneficiaries, which is really primarily the issue articulated to Medicare.

You highlighted that there's a lot of assumptions about how the industry will react in doing these

calculations, and if I recall when I looked at OACT's calculations, that they assumed that 75 percent of the supplemental rebates would be passed through down in lower pricing, which I don't know how they got there.

I want to highlight that. Chris, you tell me if I'm wrong. That's a fairly big assumption that we're going to see that dynamic play out. Because I think everything is so interrelated here and that it doesn't really accomplish the policy objective as stated when it applies to Medicaid, it begs the question whether or not we should be going down this path at all for Medicaid.

Again, maybe someone could make a good argument to me why. I'm just concerned that it's actually going to have a larger negative impact for states than I think what we're anticipating, and again, it's hard to tell because we just don't know how the industry is going to react.

VICE CHAIR LAMPKIN: But if they don't lower their prices, if that assumption is wrong, then there's less impact on Medicaid.

COMMISSIONER GORDON: Or if they do -- yeah. That gets back down to it, yeah, because of the way the calculations were, and I just don't know if the

assumptions, if it's 100 percent of that gets passed through.

I have a feeling that the manufacturers are already doing the calculations on this and will figure out the interplay.

VICE CHAIR LAMPKIN: And there's nothing in the whole scheme of this that requires the manufacturers to lower any price for anybody --

COMMISSIONER GORDON: No.

VICE CHAIR LAMPKIN: -- at all versus taking the rebates and putting them in their pocket, it sounds like.

COMMISSIONER GORDON: That's correct. That's correct.

I guess that's my point. My point is there's a lot of interplay here, and it seems like we're talking about different levers we can pull to minimize potential impacts, assuming the manufacturers are going to do something that we don't know if they're going to do it, which way they'll do it, and really if the objective is to really ensure that the benefit of the savings is actually going to get into the hands of the beneficiaries, it really doesn't really apply here in Medicaid. I feel like we're

just doing this artful dance in Medicaid to figure out how it's going to play out when the policy really -- as stated, the policy objective doesn't really work in Medicaid.

VICE CHAIR LAMPKIN: So it's almost like -- and I think this is coming out of several -- almost everybody's comments. So this is a really interesting experiment to see if it helps and relieves the burden on the Part D beneficiaries, but what kind of guardrails can we recommend that they put around it to minimize adverse effects on Medicaid.

Toby.

COMMISSIONER DOUGLAS: I mean, just on this, why Medicaid is in it, the other piece -- and Chris' presentation highlights these levers around carving the drugs out of managed care or the supplement rebates, which really means around having a uniform formulary, which are really big tension points in states from both sides, from the managed care plan and states, and this is driving not just the financial issue, but then it could drive policy decisions of moving states in certain directions.

So, again, I just, you know, what Melanie -- we need to keep Medicaid out of this because it's driving

unintended consequences financially as well as the way of the delivery of care.

VICE CHAIR LAMPKIN: Bill.

COMMISSIONER SCANLON: I would just think we might need sort of a legal analysis here. I agree keeping Medicaid out of it would be the most clean solution, but there is a question of the Department was facing, wanting to do this without explicit statutory authority, using the anti-kickback statute, and there's a question of what kind of latitude they have within the anti-kickback statute to separate Medicaid and Medicare, and that that's for a lawyer and certainly not an economist.

VICE CHAIR LAMPKIN: Anybody else? Questions for Chris or comments?

COMMISSIONER GORDON: I don't want my comments to be confused with -- I mean, I think the objective of what they're trying to achieve, particularly on the Medicare side, I think there's some interesting policy goals that they're trying to achieve. It's just again from Medicaid, it doesn't seem like it translates as cleanly, and maybe I'm missing something.

VICE CHAIR LAMPKIN: Okay. Any members of the

audience like to make public comment on this topic?

PUBLIC COMMENT

* MS. GARRO: Good morning. I'm Niki Garro, senior director of Policy with the Leukemia and Lymphoma Society, and I just wanted to maybe point out to the Commission that this is a very short timeline for big changes for both Medicare and Medicaid, and perhaps, given the uncertainly with assumptions and the data about how it's going to impact Medicaid, perhaps suggesting that the timeline be extended so that it can be properly evaluated and how it's impacting the Medicaid population.

CHAIR THOMPSON: I'm sorry. Did you mean the timeline for implementation --

MS. GARRO: Yes.

CHAIR THOMPSON: -- or the timeline -- yeah. Okay. Not for public comment. Right, okay.

MR. ISMAILI: Hi. My name is Craig Ismaili. I'm with the National Health Law Program, and I was wondering if there was any evidence from any of the studies about the effect of the drug pricing changes on Medicaid beneficiaries, especially in the higher federal poverty level ranges that were paying 20 percent of the list prices

before.

MR PARK: For most states, the Medicaid beneficiaries' copayments are nominal. They're only a few dollars. I don't know off the top of my head if any states has taken up that option for the highest income groups to do the 20 percent of -- you know, 20 percent coinsurance.

VICE CHAIR LAMPKIN: Any other members of the audience with comments at this time?

[No response.]

VICE CHAIR LAMPKIN: Darin.

COMMISSIONER GORDON: Chris, do you have any perspective on how this would impact the Part D clawback for states?

MR. PARK: I do not. I know they use like a Medicare drug spend trend or the national drug spend trend to inflate the clawback baseline, but I don't know how this would potentially affect that.

COMMISSIONER GORDON: I know, I mean, it's baseline, but the process, if there was an overall change in the spend, that that would trickle down to the impact, you know, reduce any increase or changes in the Part D clawback. I'm just not sure how that interplay would work.

I'm just curious if there something we're -- if they do this on the Medicare side, if there is a greater benefit, and I don't recall seeing anything in OACT about it.

MR. PARK: I don't think anyone specifically mentioned that issue.

COMMISSIONER BELLA: I think it could probably go either way, depending on what happens with -- yeah. So yeah. I don't think it's a given that it would go down, and there certainly is a lag. But, anyway, I think it probably could go either way, depending on, again, this sort of speculative behavior about -- yeah.

VICE CHAIR LAMPKIN: Can we return to the slide where you had made various options that we could consider commenting on?

MR PARK: Yes.

VICE CHAIR LAMPKIN: So let me try to get a sense of where people are in terms of thinking about whether we should respond to this rule and make some comments related to mitigating potential adverse effects on Medicaid and what we think those areas are. Are you guys generally inclined to respond?

Okay. Should we consider each one of the

concepts that Chris has put out there and then solicit additional commentary that people would like to add, if any? Just get a sense.

So I'm back at the text now, Chris, on page 9 of the materials you'd given us. You had said we may want to express concern in proceeding while there's significant uncertainty on the effect on Medicaid. I don't think I was hearing that as much from Commissioners as much as specific concepts to mitigate the effect. Is that generally where people are?

COMMISSIONER CERISE: Right. Yeah. I mean, what I'm hearing is that there is a significant uncertainty. So even though the number, you know, the $1.9 billion over 10 years seems, you know, that's one estimate but beyond that there seems to be still uncertainty in how this would play out, including supplementals. And, you know, what you each pointed out is you expect -- there's no guarantee you're going to get the reduction in prices, so that may not happen, and there could be a negative impact on Medicaid that we're not sure about.

And so what I'm hearing is, I mean, concern, and to expressing a concern that this is going out there that

could have a significant negative impact -- or, well, it could have a negative impact on Medicaid that we don't understand yet. So I would certainly be in favor of expressing those concerns, like Chris had laid them out.

CHAIR THOMPSON: Okay. But, Fred, would you agree, though, with the caveat that if the primary policy driver is to provide a benefit to Medicare that we want to respect that and recognize that those are not policy objectives that we're evaluating against.

COMMISSIONER CERISE: Yeah, I agree. I don't want to get into, you know, how do you provide a benefit to the beneficiary that they've calculated in Medicare? But even the -- you know, it's one thing to carve out the Medicaid MCOs but it's also just the price changes itself are going to have an impact that I think is worth, you know, commenting on.

VICE CHAIR LAMPKIN: Alan.

COMMISSIONER WEIL: I want us to be careful here. There is no question that the purported goal is to return dollars to Medicare enrollees, but the uncertainty is whether that will happen. The mechanism -- I would prefer we focus on the mechanism -- the proposed mechanism is to

instead of having a list price rebate structure to have a single price, a unified price, where the list price incorporates the cost of having rebates in Medicare. That -- if it's -- if, as you noted, if it brings prices down that has positive effects for Medicare beneficiaries. If it doesn't bring prices down it has no positive effect for Medicare beneficiaries. It has also the distributional consequences of whether you get the dollars into the premium, which helps everyone, or you get the dollars at point of purchase, where it helps the people who are high utilizers.

So there are lots of distributional consequences. I would really prefer we stay out of that. I think the issue is that what the rule does is it change the hydraulic of list and rebate, and there are, because of how Medicaid rebates are calculated, there are uncertainties about how changing that hydraulic will affect Medicaid costs. That, to me, is the point of entry. There is also uncertainty about application to managed care, and maybe there's uncertainty about supplemental rebates.

But I would focus on the changing hydraulics, not on the goals, and say we aren't talking about the goals,

because I don't think we really know if the goals will be achieved.

VICE CHAIR LAMPKIN: Yeah. Totally makes sense. And along those same lines, so one of the things that Chris has suggested to us is we recommend clarifying language that protects the supplemental rebates. Is that something -- that seems worthwhile to me. Is there anybody who doesn't think that we might include that in our comments?

CHAIR THOMPSON: Well, I guess the question is do we just want to say, sort of following -- which I totally agree with that, the way that Alan has structured the kind of like frame of our commentary -- that here are the uncertainties and the places in which this could play out in a way that's detrimental to the Medicaid program or to beneficiaries, and we're expressing concern about that.

We don't know necessarily what the right answers are to address that because we're not going to have a legal analysis, and I don't think it's proper for us to necessarily, you know, figure out what the fix would be. We could identify some things that were part of a discussion or that the Commission has thought about, like could you take Medicaid out of the equation entirely with

respect to certain things? Could you change -- you know, could you do some compensating change from a policy perspective, with respect to other things, et cetera? We could lay those all out as things that could happen, but without necessarily, I think, try to say the fix for this is that, the fix for that is this, to mitigate this we do that. Because I think with a lot of uncertainty and questions about pieces we might not be in a position to --

VICE CHAIR LAMPKIN: Okay. So would we want to include the concept of rebasing, that Alan suggested earlier, as one of the examples of things in that context?

CHAIR THOMPSON: I would say so. I would say we don't have to necessarily say we -- you know, that's the answer, or -- but that that's part of the ways in which you might respond to that.

VICE CHAIR LAMPKIN: Okay. Any other comments or additions to that approach?

[No response.]

VICE CHAIR LAMPKIN: In terms of next steps, then I think, Chris, you mentioned that responses were due -- comments were due prior to our next meeting, so you all will take the lead in drafting a letter along these lines.

Do we -- is there anybody who particularly wants to be added to the draft letter review process?

COMMISSIONER WEIL: I'm willing, if that's what you're looking at.

VICE CHAIR LAMPKIN: Thank you, Alan.

CHAIR THOMPSON: Bill.

VICE CHAIR LAMPKIN: Oh, and Bill. Thank you both. Thanks, Chris.

CHAIR THOMPSON: Okay. Great. All right. We're going to move on to the last topic on our agenda. We're a little bit ahead so I'm going to not give us a break but of course invite anyone who wants to take a break to do so, and we'll go ahead and jump into Kristal's presentation on care coordination requirements in integrated care models.

And we'll just give -- Kristal, just take a minute here while people are making adjustments before you kick us off.

[Pause.]

CHAIR THOMPSON: All right, Kristal. Thanks. Take us away.

ANALYSIS OF CARE COORDINATION REQUIREMENTS IN INTEGRATED CARE MODELS

* MS. VARDAMAN: Good morning, Commissioners. During this meeting cycle the Commissioners have been exploring various aspects of integrated care programs for dually eligible beneficiaries, beginning with an October panel of state officials. Last month, Kirstin brought you the results of contractor research, conducted --

CHAIR THOMPSON: I'm sorry to interrupt you. Can you just bring that a little bit closer to you? I think it would be helpful. Thank you.

MS. VARDAMAN: So last month Kirsten brought you the results of the contractor research on factors that determine enrollment in the Financial Alignment Initiative, and today I'll be discussing with you the second of three contractor research projects that we engaged in this year. The topic of today's is on care coordination in integrated care models.

I'll begin with a bit of background and then I will describe the results of work that was conducted by Health Management Associates for us, and end with a few discussion questions.

Before I go on I'd like to just take a moment to thank Sarah Barth and her team at HMA for their hard work

on this project. The full report is in the editing stage and we expect to have it published this spring.

I won't spend much time on background since we've been here so recently, but just as a reminder, states and the federal government are currently pursuing a variety of integrated care models. States are often engaging in more than one of the options that are listed here on the slide, and integrated care models aim to provide a better management of beneficiaries' care and also to help to reduce or manage the cost of that care.

Given that many dually eligible beneficiaries have complex medical needs, care management is an important part of integrated care models. For example, care management can help to manage care transition such as those between acute care settings, when beneficiaries are going back to the community, often with the aid of long-term service and support that have to be set up. They can help to coordinate across Medicare and Medicaid benefits, which can be very complicated and confusing for beneficiaries. They can also help to reduce poor outcomes such as avoidable hospitalizations. And care coordination processes can also help to connect beneficiaries with

services that help address social determinants of health, such as housing or food insecurity.

States include standards for care coordination in contracts with managed care organizations or MCOs, and there are several studies in the literature that examine these standards in a number of integrated care models. Given that there has been a more recent focus among states in aligning managed long-term services and supports, or MLTSS, with dual eligible special needs plans, or D-SNPs, there is less information on those contracts and how states are coordinating across those two contract types.

So in order to understand how care coordination requirements vary, both across models and across states, we contracted with HMA and they engaged in the following activities. First they catalogued contract requirements for the Financial Alignment Initiative, or FAI, demonstrations, MLTSS aligned with D-SNPs, and fully integrated special needs plans, or FIDE-SNPs. Next they interviewed a variety of stakeholders to understand how these standards operate on the ground. Their final report synthesizes the findings to describe emerging state practices for, and challenges to care coordination, and to

identify similarities and differences across the various integrated care models.

So these are the states for which HMA reviewed contracts, for a total of 32 contracts. You can see here that several states are participating in multiple models and these are the models that are managed by managed care organizations.

On this slide we've listed the contract elements that HMA reviewed. So I won't read them all but they included training for care coordinators, case load ratios, and how care transitions were managed. So for the final report there will be an appendix where HMA lays out, for each of these contract elements, which of the state contracts had standards that related to each of those elements and describes them.

Next I'll move on to discuss some of the key findings from the contract review. First, some states have more detailed contract requirements in both their MLTSS and D-SNP contracts. So, for example, Arizona, Tennessee, and Virginia all had contracts that were both more detailed than others on the MLTSS and D-SNP side. These are states that have very mature managed care programs and so they

perhaps have more time to have their contract standards evolve over time. And so that was something that was notable in their contracts.

Next, most of the contracts required some care coordination or involvement in care transitions. So, for example, in Virginia, the MLTSS contract had a requirement that plans have at least one dedicated transition care coordinator in each region whose caseload was completely comprised of individuals that are in transition, and that could also work with the D-SNP care coordinator to manage those transitions.

Contract requirements often include requirements for information technology, data sharing, and reporting. As some examples, Massachusetts requires that its FIDE-SNPs have a single enrollee record that's centralized, and in Tennessee the MLTSS contract requires some data sharing with D-SNPs for dual-eligibles, which includes things like standardized reporting for discharge planning.

However, contracts did not typically require, or specify requirements for care coordinator training. There were some exceptions, but there wasn't a lot of specificity in how those trainings should be conducted.

The next set of findings, first I'll start off with most HRAs in the MLTSS plus D-SNP programs were not specifically tailored to dual-eligible beneficiaries. They typically still have one HRA for the MLTSS side and one HRA for the D-SNP side. But there were some requirements for each of those sides of the contracts in regard to how they should assess dual-eligible beneficiaries. However, most of the FIDE-SNP contracts did require using an integrated HRA.

Next, in regard to caregiver involvement, many of the contracts refer to inclusion of caregivers in the care planning process, and finally, contracts varied in their specificity regarding how to incorporate social determinants of health in care planning.

So as one example, Arizona's MLTSS contract required plans to have designated staff with expertise in housing, education, and employment issues and resources. However, a number of other contracts lack specificity about how social determinants should be incorporated into assessments and care planning, and just were more general in terms of saying that they should be, without a great

deal of detail.

Next I'll discuss the results of the stakeholder interviews. HMA interviewed a wide range of individuals to gather different perspectives on how care coordination requirements are working on the ground. They engaged with the Centers for Medicare & Medicaid Service, Medicaid officials from Tennessee and Virginia, also health plan associations, medical directors, some consumer advocacy organizations, and some home- and community-based services or HCBS provider associations.

And, in general, there were a lot of things that stakeholders said that were similar, in terms of their perceptions of how things are working, and there were a few areas where there were some unique concerns for certain groups of stakeholders. So I'll try to highlight some of both of those.

First, everyone really did talk about the importance of locating and engaging beneficiaries. I think there has been some, you know, well-documented challenges that plans have had in identifying dually eligible beneficiaries, and so there was some discussion about that and its importance in engaging beneficiaries in their care

management.

Next, there was a discussion of focus on care management and care transitions in all the integrated care models. So this was consistent with the contract review findings, that stakeholders felt that there had been a concerted effort to make managing care transitions a focus in the care coordination process.

Next, plans said that they preferred more flexibility in contract standards. Again, there are certain states which had more prescriptive detailed contract requirements. However, in one state, one state official did note that while there was some resistance initially to the more detailed requirement, over time the plans had expressed that they did appreciate having, you know, the expectations to be clear, and that, you know, some of the concerns dissipated over time.

Next, technology solutions were identified as having potential to support care coordination in real time, so increasing more use of data sharing and things like that. And finally, in this section, the cooperation of social determinants of health in care planning is evolving, and so there was a lot of discussion about how plans are

learning about the best ways to address social determinants of health and trying to continuously improve in that area.

In terms of some of the challenges that stakeholders brought up -- and this is an area where there was, you know, some unique concerns across different stakeholder groups -- the first one I think was commonly shared, a concern about difficulty engaging with primary care providers, as dually eligible beneficiaries in these plans may comprise a small number of their, you know, patient panel, and so there can be some challenges trying to get them to participate in things like interdisciplinary care team meetings.

It was also noted that there have been some challenges coordinating across MLTSS and D-SNPs. This would be for beneficiaries that are in unaligned plans, so they're in an MLTSS plan with one organization and a D-SNP in another, that challenges can remain. In Virginia, they do require that the D-SNP plans request a representative from the MLTSS plan to be a part of the care planning process, but we did hear that, you know, it can be difficult to get that coordination to actually occur, even though it is something that they request. Managing

timelines and things like that can be difficult.

Next, there was a discussion about some strained relationships between nursing facilities and care coordinator relationships, that nursing facilities can be resistant to care coordinators coming into the facility and engaging with the residents there. Some plans are finding ways to better partner with nursing facilities by embedding a care coordinator there to be a resource and to help to, you know, coordinate care with beneficiaries but to have a more collaborative relationship.

From consumer advocates we did hear that there's been some concern about how they're being engaged and collaborated with, particularly around care coordinator trainings. There was a feeling that there was more opportunities for the beneficiary's voice to be a part of care coordinator trainings. And then, finally, HCBS providers particularly felt that they had been underutilized in care management, that they are in beneficiaries' homes often daily, have relationships with the beneficiaries as well as their family members and other caregivers, and have, you know, information on a, you know, frequent basis that could be better engaged with the plans

around care coordination and care management.

So that's the overview of some of those findings. Here I've set up some questions for further consideration. First, what's the right balance between contract prescriptiveness and giving plans flexibility to innovate? Again, we heard a variety of perspectives on that during the interview process.

Second, how will care coordination practices continue to evolve? We heard a lot about, you know, innovations and social determinants of health and addressing them being an area of focus for plans and states going forward. Also, again, in terms of engaging with beneficiaries, having more face-to-face interaction was something that came up in several interviews, that particularly for beneficiaries with more complex needs there may be need to be more opportunities for face-to-face engagement.

And then, also, thinking about how to overcome challenges in accessing care coordination approaches. You know, we started this work hoping to be able to say something about how they, in these standards of care across states and across contracts, and we were able to describe

that. But in terms of thinking of how to understand what should be replicated across different states, without more information on outcomes measures that are important for LTSS populations, for example, and, you know, data availability challenges, are there ways that we can better assess in the future to be able to understand how to make recommendations to states as they continue to implement or refine these programs?

And with that I'll turn it over to you.

CHAIR THOMPSON: Great. Thank you, Kristal, and thanks to the HMA team for pulling this information together.

I did just want to kick off to the Commissioners and ask some questions, very much kind of following where you've left us in this conversation about, you know, as I looked at information about specificity of contract terms. You know, you think about that both as a matter of -- and I'd be curious to hear Stacey speak on this issue, particularly, but others that have had to be in a position of actually bidding on work. Like does it help to be in a position to adequately resource your bids if you know what's required, and so does specificity help in terms of

making sure that there's adequate capacity to do all the things that need to be done?

And then, you know, the other side of this being, you know, does it sometimes mean that resources are put towards less productive activities where there might be some opportunity for creativity and innovation and even differing approaches for different subpopulations and in a way that better produces the results that we're seeking? And you could easily see how there's sort of puts and takes on both sides of that. But I don't know, Stacey, if you had some observations that you would want to share along those lines.

VICE CHAIR LAMPKIN: Well, from a pricing perspective, sure. If there's a minimum standard right there in the contract, that makes things a lot easier. We do see, though, from time to time that even when the minimum -- just even getting the minimum standards right can be challenging. So there's that. And then there's also a very divergent point of view in the models that different plans may use and in the way they react to minimum standards, that then kind of means that as simple as the pricing might have seemed based on the minimum

standards, it's not really that simple. So it just seems like plans do different things based on their models in reaction to something anyway.

CHAIR THOMPSON: One thing, Kristal, we talk about contract terms and we talk about them as though they are all minimum standards. So my question is: Are sometimes the contract terms about earning incentives? Or are they always when we're talking in this context about requirements?

MS. VARDAMAN: So when HMA -- I'm looking at their appendix here. I don't have any examples that I can think of that they came across where any of this was tied to incentives. I could review and take a look or ask them again, but I'm not sure that came up.

CHAIR THOMPSON: Okay. I don't know if that's something that's common that you've seen, Stacey, or if it mostly is all minimums and requirements.

VICE CHAIR LAMPKIN: For care coordination specifically, my personal experience is more with a floor-type spec.

CHAIR THOMPSON: Melanie and then Kit and then Brian and then Peter.

COMMISSIONER BELLA: Thank you. I have a couple of comments. One, I am always appreciative of the work that is being done in this area.

One is just a request, that in the final document, that it's very, very clear the differences between -- when we're talking about the MLTSS and the D-SNP and the FIDE and the demo plans, because even sometimes in this -- and I realize this is a summary -- it blurred a little bit. So, for example, I would say MLTSS and D-SNP don't have tailored HRAs, but it wouldn't say whether the other two do. And, you know, the demo plans do. That's how -- everything is tailored to duals. And so I just want to be very clear that in my mind this is very much a continuum of integration. It's not surprising to me that the D-SNPs plus the MLTSS have the least integrated, least tailored things. They're the least integrated product of the three.

And so I think as the Commission thinks about our work in this area and how we're trying to support the goals of pushing integration and raising that bar higher, we should always be thinking in the context of like moving along this continuum, and these, what you're finding I

think supports that, because the things that are in the FIDE-SNPs and in the demo plans seem to be more -- driving toward integration and care coordination.

Now, that said, a couple other comments on that. I'm not saying any of that is perfect. I think when we think about care coordination, there's an element of what the states require, but there's also an element of how the health plans organize themselves. And so when the health plan who has a D-SNP and an LTSS contract keeps those contracts in two separate parts of the business and assigns two separate care management -- I mean, so we have to -- so it's not just what the states -- and the states can help that. But if they're still fulfilling the contract requirements by organizing them in two completely separate silos, like the contract requirement isn't really getting at that. So it's just a piece I think we have to recognize.

The third thing I would say is, as we continue to do work in this area -- and Penny mentioned this -- I think it's really important to be drilling down into subpopulations. So, for example, when we're looking at any of these requirements, whether it's HRA completion, care

coordination, care management engagement, it's really different -- it can look like 85 percent, but it's really different as to whether it's like how people with severe mental illness are participating in care coordination or any of these things versus how the elderly -- and so it's just -- that to me is the most important thing that we don't understand and that we're not able to help policymakers understand what kind of requirements to have.

So that leads me to my last point. Thank you for indulging. As far as contract prescriptiveness, I think that we -- it does -- there can be more flexibility around certain portions of the population than others. I mean, I'll tell you from having done the demos, the reason some of those are so prescriptive is because it was brand new and there was a lot of fear about what was going to be done or people would have a bad experience. And so things tended to be pretty prescriptive. But that played itself out to say like in Massachusetts you have to have something done in the home within 90 days by a nurse. You don't need that for everybody, right? So it's to your point about how we're best using resources, but until we can shine some light on the subpopulations, we're not going to be able to

kind of dial those levers up and down on the prescriptiveness. And I think there's a great opportunity to move there, and I would just encourage us to be pushing our contractors to be really drilling down into smaller groups of the population.

CHAIR THOMPSON: Good. And, you know, that reminds me of a conversation that we've had. Bill, you've made this point previously about subpopulations and particularly vulnerable folks and, you know, how much we know about them and how much we're paying attention to their experiences particularly.

And then the other point that you made, Melanie, that I think is interesting is that when you're starting off doing something and how you write it, I think sometimes what happens is the contract terms get written in a certain way, and then they just become additive and additive and additive, and nobody's ever going back and kind of re-evaluating. You know, have we moved past this? We're less concerned about this because it's more embedded now in culture and practice. And now what we really need to focus people's attention on is kind of raising the bar in the following ways. But that's always a tension in terms of

feeling like you lose something by doing that rather than understanding what you gain by dog that.

Kit?

COMMISSIONER GORTON: So I would align myself with what Melanie was saying. I want to build on a couple of things.

Sometimes in order to get a sense of security among some stakeholder groups, particularly members, families, and advocates, you need to build more in in order to give yourself room to actually do this. We saw this in the rollout of managed care back in the 1990s, or seeing it in the evolutions of that, you commit greater levels of resources in the beginning to sort of create the sense of security that allows you to proceed with the program.

To your point, Penny, we need to be sure that we don't get this sort of accretive coral reef kind of growth of these contracts' terms and conditions and that, you know, once people are feeling more secure, you can go back and maybe clean up or streamline some of those things.

To the question, Penny, that you asked Stacey, the potential perverse incentive is the more specific you are, the more people will bid to the floor and be done.

And they won't do above and beyond because essentially the program has been specified. So all you're doing is coming in with your best price to do it better, faster, cheaper to the specified program.

Which takes me to my answer to Kristal's first question, which is these are demonstrations. There is no right answer. We don't know which way works. And past experience with managed care says there won't be one right answer for every community and for every subpopulation. And so we need to figure that out, and this is where the state-federal partnerships and the opportunity to try things out, this is where it has its richest opportunity to produce new models. And so I don't think we want to get too prescriptive too fast. I don't think we want to hem people in. Some ideas are going to sound like they're good things, and then -- you know, I would say in the Massachusetts example, I'm not sure I've seen evidence that the centralized enrollee record creates value. It creates a heck of a lot of expense, and it creates a heck of a lot of administrative burden, and people are fond of pointing it out. But, you know, I would say that -- at least at our plan, I don't know that I would say that it creates a lot

of value.

And, by the way, when people change plans, that record is a plan-specific record. It doesn't translate over.

So I think that we need to be cautious about those things. Care coordination practices will continue to evolve, particularly based on subpopulations, and you need a different set of care coordination practices to deal with a predominantly Cantonese-speaking population of seniors in South Boston as opposed to a population of middle-aged people with substance abuse disorder and serious mental health problems living in Worcester. And we saw that break out even in terms of medical expense across counties, but the profiles are very different.

So the coordinating practices will continue to evolve, and I think we need to be careful that we don't constrain that too soon. And the flip side of it is I think we need to be careful and disciplined about doing the evaluations and figuring out what works, which is your final piece. You know, we've talked in various ways in this meeting and in previous meetings about the challenge of evaluating demonstrations. I just think that needs to

continue to be an ongoing message from the Commission. If you're going to try your stuff out, that's cool. But you've got to figure out whether it works or not. And whether it's ROI on program integrity programs or other things, at some point, you know, to paraphrase St. Augustine, you need a well-examined program to be worth running. And so, you know, that is my Lenten message.

And so I do think that -- I do think we tend to skimp on program evaluation, and I would just underscore that I think to the extent that the Commission can push all of the stakeholders to continue to value program evaluation, I think that's a good thing.

CHAIR THOMPSON: Brian.

COMMISSIONER BURWELL: So I think I've said this before. The care coordination in MLTSS programs and integrated care models is a special interest of mine, and I really -- I have always strongly felt that high-performing care coordination is essential to meeting the goals of true integration. The care coordinator is the person who's most engaged with the beneficiary on a daily basis, knows the beneficiary the best, is in the best position to meet the unique needs of every individual, and I just think, you

know, they're key to the success of these models.

Also in my work, I've always tried to accompany care coordinators on home visits in different MLTSS programs and across plans, et cetera. They've been some of the most interesting experiences in terms of how they deal with the beneficiary needs and how they respond to them.

I agree with Melanie that as we continue to do this work, we should do it within the prism of our policy, our goal of how to promote true integration across Medicaid and Medicare and what levers we can enact or promote in care coordination to promote that overall objective.

Having said that, I want to -- I mean, I think looking at standards in contracts between states and plans around care coordination is a piece of that, but it's only a piece of that. I mean, what's written in a contract is -- you know, they're just words in general, and I've visited different plans in the same state operating under the same contract language, and the quality of the care coordination is dramatically different across the plans, and it has to do with culture, it has to do with organizational mission. You know, so it's not -- I don't want anybody to feel like, you know, the policy issue here is how we write good

contract language. It's not that.

A couple of things I'm surprised that HMA didn't pick up in this work, which is, you know, there are MLTSS programs or Medicaid-only plans versus integrated care plans, and integrated care plans that really are attempting to coordinate both Medicaid and Medicare benefits. There's a need for more medical professionalism so that care coordinators kind of more understand the Medicare side of the equation. And so often their -- I've often seen their contract language about in integrated care models the plans have to have a certain amount of nursing care coordinators within the mix, you know, that they appropriately assign people according to their medical conditions or they team nurses with social workers, et cetera. I'm surprised that didn't come through.

I'm also surprised that a lot of contracts deal with kind of cultural and ethnic alignment; you know, a high percentage of duals do not have English as their first language. You know, they're a highly diverse population. Often states are trying to ensure that plans are hiring care coordinators that are culturally appropriate to their populations. I'm surprised that that was not one of the

factors that came through in the contract language.

MS. VARDAMAN: Can I just jump in quickly just to respond?

COMMISSIONER BURWELL: Sure.

MS. VARDAMAN: So in terms of the medical professionalism, there will be an appendix and some of the qualifications of care coordinators. Some of the states did have different scenarios or levels at which, you know, for some maybe it's one scenario, a beneficiary could have someone with a bachelor's in social work, but at a different level they would require someone with a master's or a nursing degree and things like that. So there will be some of that detail.

COMMISSIONER BURWELL: Good. I think that there's further work to be done in this area, I mean, beyond just the contract language part. As I said, I think it's only one piece of the issue, but, you know, I encourage us to do continued work around what constitutes a high-performing care coordination system for integrated care models.

And I just have a side question. What is the third study that we're doing in this area?

MS. VARDAMAN: Sure. So the third study, we had a contract with SHADAC at the University of Minnesota to do basically an inventory of evaluations and studies that have been published both in the peer-reviewed and sort of gray literature on the outcomes of integrated care models. And so we've been in the final stages of kind of fine-tuning the editing of that, and we're planning to publish it on our website. So it's kind of a landscape in Excel with summaries, and we'll also have an accompanying --

COMMISSIONER BURWELL: So it's like a mega analysis of existing evaluations?

MS. VARDAMAN: Yes, and we'll also have an issue brief accompanying that with some themes on it. So we plan to bring some of that to you next month.

COMMISSIONER BURWELL: Great.

CHAIR THOMPSON: Thank you, Brian. Peter.

COMMISSIONER SZILAGYI: Thank you very much. This probably mostly reflects my naivete. So two points. One is a question. When I was in Rochester, New York, and very involved with a managed care organization, it wasn't dual eligibles, but we had many, many care coordinators. And one of the unusual challenges we encountered was some

confusion across multiple care coordinators. So health systems had care coordinators. We had care coordinators, sometimes practices. And I was surprised to hear that not being mentioned as a challenge. Was that more specific to Rochester, New York, or --

MS. VARDAMAN: No, I definitely think that's come up in some other work we've done around MLTSS, also when we did several years back some focus groups with beneficiaries enrolled in the demonstration plans about, you know, not just -- even if in the demonstration plan they may have had one care coordinator, but they may also reside in a senior living place where they have someone else who they go to a lot for questions around, you know, other issues. And so there was often confusion about, you know, "I talked to this person." But that's actually not the plan care coordinator. That's, you know, the social worker embedded in their senior housing.

COMMISSIONER SZILAGYI: So we do actually try to develop a system where -- and, Brian, I totally agree with you in terms of the super-importance of care coordinators, where one person was the primary, whether it was the health system or the managed care. Maybe that was unusual.

And the second point, which may be, again, more of a question, I'm always in favor of more flexibility if there's little evidence base. And I'm always in favor of less flexibility if there is an evidence base. And I'm kind of surprised -- is there not really an evidence base for this population, for a subpopulation, let's say dementia care or stroke victims, for key elements of care coordination -- not integration so much but care coordination? Because in a pediatric world, which is totally different, there is a developing evidence base for care coordination. There's kind of an 80-20 rule, that 80 percent of it is not related to the chronic problem, 20 percent of it is. There's components of cultural -- you know, there's multiple domains that have been kind of worked out. Is there no National Academy of Medicine or other sort of evidence base on this for sort of the elderly or sort of the tool.

MS. VARDAMAN: I'm not --

COMMISSIONER SZILAGYI: I'm just not familiar with the field.

MS. VARDAMAN: I'm not aware of any. I mean, I do know that certain states have developed some specific

trainings around certain populations, like people with Alzheimer's disease, and so there are certain, often training of care coordinators on the importance of, you know, considering certain considerations for that population. But in terms of national standard I'm not aware of any. I don't know if Brian or any others are.

CHAIR THOMPSON: I think that is an interesting question, I mean, because it does come back to this question of what results do we achieve by some of these requirements, and the question of what evidence underlies decisions about why certain contract terms versus others. Is it just stakeholder comfort level, you know -- which I don't minimize that. You know, protections are important and for people to feel protected is important –

COMMISSIONER SZILAGYI: But it -- I'm sorry.

CHAIR THOMPSON: -- in terms of achieving the results of integration that we're seeking, right, what are the techniques and approaches that really help ensure, especially, again, for some of those subpopulations, that their care is being managed in a way that's really helping them stay as healthy as possible.

COMMISSIONER SZILAGYI: And I just really wanted

to support what Kit was saying, that, I mean, if there is not really acute care in this space we really need these results of evaluations, and we need flexibility, because these are kind of multiple, multiple experiments going on.

CHAIR THOMPSON: Sheldon, you're looking to jump in.

COMMISSIONER RETCHIN: Yeah. One thing that struck me, and maybe because I've been on also the side of being in the demonstration in the beginning in Virginia, was the comment that was made, Kristal, by stakeholders, of particularly care coordinators, on engaging primary care. And I was curious to the depth of their comments, how descriptive they were, and whether there were any comments on the level of dedication to specific providers, that is, a primary care provider who, let's say, has a panel of 100 or 200 patients in a coordinated care -- an integrated delivery model, versus someone who is taking on one or two patients, or variations on that.

Further, whether there was any mention about primary care providers in terms of who employs them and how they're paid, if there was any discussion on that. Because I was particularly struck, also by the lack of

participation by primary care providers in team meetings. No surprise there, unless there's a sort of a staff model approach to that, where they're actually employed. I'm just curious.

MS. VARDAMAN: Sure. There were a couple of examples, in terms of details, some of the strategies that individuals raised in terms of how to improve engagement. One was having a case manager come to the provider's office once a week to discuss all of the members that are served by that provider, in order to reduce burden, sending the care plan through a variety of means. There was also some discussion around whether, you know, plans are exploring incentives and value-based arrangements to try to engage primary care providers in care coordination and try to reduce silos. So there are some details around that.

CHAIR THOMPSON: I wondered if there was any -- this Commission has previously discussed, in various ways, over the years, the issue of state capacity. And was there any conversation about the relationship between state resources and expertise and what's happening inside of these contracts and how they're being written and how they're being monitored in terms of actual implementation?

MS. VARDAMAN: Well, we interviewed two states that have quite a bit of experience in this area, Tennessee and Virginia, and so for them there was some discussion just around how their contract standards have evolved over time. And, like I said, I think you could see the difference between Arizona, Tennessee, and Virginia, and some states with less experience in terms of how prescriptive or -- not prescriptive but how sort of layered and sophisticated that their requirements were, compared to others. But in terms of like general concerns around state capacity in other states we didn't hear a lot of that, but it's partially due to who we talked to.

CHAIR THOMPSON: Brian, do you want to jump in?

COMMISSIONER BURWELL: Remember when we had a panel of a couple of states around MLTSS -- Virginia and Arizona, and Karen Kimsey from Virginia particularly spoke about the lack of capacity and expertise around Medicare. So if they're developing contract language that involves coordination of Medicare benefits, I mean, a lot of people in the state don't really understand what a D-SNP is or a Medicare Advantage plan, and like how can they write contract language if they don't really understand, you

know, those models? So I think there was an expressed need for greater -- and they were asking for technical support from CMS in terms of providing more support for Medicare expertise at the state level.

CHAIR THOMPSON: Let's take a pause and see if there are any public comments that we should consider before we conclude this session.

PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: Okay. Any other commentary from the Commissioners?

[No response.]

CHAIR THOMPSON: Kristal, thank you very much. I think you can see there will be a lot of interest as this report is published for the Commissioners, and obviously then for the members of the public, to be able to dig into the details here. There is, I think, a lot of meaty information that you've provided and we'll look forward to seeing the details. So thank you for this presentation.

All right. Any final comments or questions from the Commission before we adjourn our March session?

* [No response.]

CHAIR THOMPSON: Okay. We are adjourned. Thank you very much.

* [Whereupon, at 11:06 a.m., the Commission was adjourned.]