PUBLIC SESSION

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10:02 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
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TRICIA BROOKS, MBA
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PETER SZILAGYI, MD, MPH
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ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[10:02 a.m.]

CHAIR BELLA: If you all can take your seats, we will go ahead and get started.

We have a fantastic panel. So I want to use all of our time to hear from these folks. Let's go ahead and get started.

PANEL: INTEGRATING CARE FOR DUALLY ELIGIBLE BENEFICIARIES: PERSPECTIVES FROM BENEFICIARIES, PROVIDERS, AND PLANS

* MS. BLOM: Thank you, Melanie.

I'll just do a quick introduction. We're continuing our examination today of integrated care for duals, which is, as always, a topic of longstanding interest of the Commission. We've been closely following federal guidance and state actions in this area, and we heard last month from federal and state officials on this topic.

Today we'll be hearing from representatives of a beneficiary advocacy organization, a provider, and a health plan. They'll share their experiences with integrated care for duals, including what works and what doesn't, as well

as barriers that they've identified.

The panelists we'll hear from today are on the ground, seeing firsthand the effects of federal and state policies on integrated care for this population.

First, we'll hear from Ms. Amber Christ. Ms. Christ is the directing attorney for the Health Team at Justice in Aging, a national organization that focuses on securing access to affordable care for seniors. She's based in the Los Angeles office and develops and implements projects and initiatives that improve access to health care and LTSS for low-income older adults across the country. She's a lecturer at the University of California Los Angeles School of Law, teaching public interest for the externship program, and prior to joining Justice in Aging in 2013 worked for Legal Aid of Western Missouri in Kansas City, Missouri. She's admitted to the California, Missouri, and Illinois bars and is a graduate of Washington University School of Law.

Our second panelist is Dr. Griffin Myers, co-founder and Chief Medical Officer at Oak Street Health, a group of value-based primary care centers serving adults on Medicare and Medicaid, which is headquartered in Chicago.

Prior to Oak Street Health, Dr. Myers did his residency in emergency medicine at Harvard Medical School at the Brigham and Women's and Massachusetts General Hospitals. Dr. Myers has a bachelor of science degree from Davidson College, a master of business administration from the University of Chicago, and a medical degree from the University of Chicago Pritzker School of Medicine. He's a fellow of the American College of Emergency Physicians, a research associate at Harvard Medical School, an instructor at Northwestern, and a thought leader for the New England Journal of Medicine's Catalyst, a Presidential Leadership Scholar, and an Aspen Health Innovators fellow.

Our third panelist is Michael Monson, senior vice president of Medicaid and Complex Care at Centene Corporation and CEO of Social Health Bridge. Mr. Monson has national product responsibility for Centene's Medicaid and complex care product lines, TANF, CHIP, foster care, Medicaid Expansion, aged blind and disabled, managed LTSS, and Medicare and Medicaid plans. These products operate across 27 states and collectively comprise approximately 8.5 million members. Additionally, Mr. Monson is responsible for Centene's overall strategy for Social

Determinants of Health, Social Health Bridge Trust, and the Centene Center for Health Transformation. Previously, Mr. Monson was the chief administrative officer and vice president of Residential Services at Village Care of New York, a New York City-based integrated health system. He joined Village Care after having spent more than 8 years at the Visiting Nurse Service of New York, the country's largest not-for-profit home-based health care company. Mr. Monson has a master of public policy from the Harvard Kennedy School of Government and an undergraduate degree from the University of Pennsylvania.

So each of our panelists will give a brief presentation, and then we'll use the majority of the time allotted for today's session for conversation between you all, the Commissioners, and the panelists.

Following this session, we'll have a break, and then we'll return for discussion of what we heard from the panelists.

So, with that, I'd like to turn it over to Ms. Christ to share her experiences with integrated care from the beneficiary advocacy perspective.

* MS. CHRIST: Thank you, Kirstin, and thank you,

Commissioners, for having me here today to talk from the beneficiary advocate perspective.

We at Justice in Aging are very committed to the efforts to integrate care that are under way, and we think that there's been a lot of progress and positive trends towards meeting the goals of the Financial Alignment Initiative, in particular. And that includes improved health outcomes, reduced hospitalizations, increasing access to home- and community-based services. There's some really innovative things happening and connecting or transitioning individuals out of nursing facilities and really working towards rebalancing that care.

But, of course, there's a lot more work to be done, and I could talk about the duals demos for probably hours. I've been living, breathing, eating duals demos for seven years, but I'm going to try to keep it to 10 minutes. And I'm going to focus on three areas that I think are particularly important from the beneficiary advocacy perspective, and that's beneficiary choice, long-term services and supports, and then I'm going to cover those D-SNP lookalikes. I think you all received a paper that we put out that's in your possession. So I'm going to spend a

little bit of time there.

But, first, on beneficiary choice, the duals demonstrations in particular are built on a foundation of being person-centered, and we think that person-centeredness should start at enrollment.

However, the duals demonstrations have predominantly used passive enrollment, and passive enrollment is not person-centered. The ability to opt out is not the same thing as voluntarily choosing to enroll in a plan.

We do not think that dual eligibles, just because they have low incomes or because they're receiving financial assistance, should be deprived of the choice that all other Medicare beneficiaries receive.

In fact, duals with their unique needs should have more expansive choice and consumer protections in place to ensure flexibility.

Additionally, we've seen in the demonstrations that there's been real experience or proven experience that past enrollment has been very confusing for beneficiaries. It has not endeared trust in the program, and it has led to disruption in care. Many individuals, the first time they

realized that they were enrolled in the health plan was when they experienced a disruption. Either they weren't able to see their doctor or their specialist or most notably, they were denied prescription drug coverage when they went to the pharmacy and couldn't get their prescription drugs. So we think that passive enrollment is not the way to go.

We recognize that passive enrollment was used predominantly to increase enrollment very quickly in the health plans, and by and large, it's been very effective at that but at a very high cost. Forty-one percent of dual eligibles opted out of the duals demonstration. MedPAC found that the individuals who opted out were individuals that had higher needs, were sicker, had higher risk scores, and also that the health plans just weren't going to meet their needs. So, when surveyed, the beneficiaries felt that these new integrated plans were not going to meet their needs, either because their doctors weren't in network or they weren't going to provide the benefits that they thought they needed.

What's more striking is that those who were passively enrolled, 25 percent of those individuals

disenrolled within the first three months of being enrolled, again, because their health needs weren't being met and also likely because they experienced some disruption in the first three months.

What's even more telling about whether the health plans were able to meet needs for those beneficiaries being enrolled is that 17 percent of those who voluntarily chose to enroll in the plans also disenrolled in those first three months. So what we're seeing is a plan membership, a subset of duals that are enrolled in these demonstration plans that are healthier. This mirrors what we see in Medicare Advantage. When individuals get sick, they disenroll.

So the health plans aren't currently at this time able to meet the needs of those individuals with the highest needs, and that's exactly what they're supposed to be designed to do. So we shouldn't be pushing individuals into health plans and, worse yet, trying to lock them in if, in fact, these plans aren't meeting their needs.

So we have two recommendations around enrollment. First -- let me refer to my notes, so I don't forget anything -- we really support a voluntary system of

enrollment. We recognize that this would be a slower form of enrollment, but it would also be more sustained.

This provides an opportunity for the health plans to build trust with providers and to really build up the robustness of the provider network. It allows for the plans to build trust with the community-based organizations and with beneficiaries themselves.

It also allows the plans to build up their capacity to serve this population. We saw in Los Angeles County, for example, health plans enrolling, passively enrolling 7,000 individuals per month. In what world do we think that there's capacity to serve those individuals? Of course, of those individuals, the highest needs were the ones who fell through the cracks, experienced disruptions in care, and therefore disenrolled. So we think that allowing for a voluntary system is the way to go and would honor beneficiary choice, which we think is paramount.

Second, we also think that in order to increase and retain enrollment, that should be through a plan design and improving the delivery of benefits, so really focusing in on the delivery system itself and what the health plans can be doing, so really focusing in on care coordination,

which has been proven to be very effective, particularly in states like South Carolina with face-to-face care coordination.

Massachusetts has really coordinating -- are contracting with community-based organizations to provide care coordination, really focusing in on those long-term services and supports. I'm going to talk about more of that in my second recommendation. And also connecting people to durable medical equipment, language access, cultural competency, strengthening provider networks and referral processes, improve communications, simpler communications, the consumer protection of deeming, which allows someone to remain in a health plan if they lose Medicaid eligibility up to a certain period of time. That would allow health plans to retain members because most of the time, those eligibility determinations are incorrect.

And that brings me to my final one, which is really robust investment and counseling, individual enrollment counseling through SHIPs, and also investments in the ombudsman programs, which can help with the deeming and Medicaid eligibility determinations, but also can help with those disruptions in care that are going to happen.

I will turn now to long-term services and supports. Again, another foundational goal of the demonstrations and integrated care is to improve the coordination and access to long-term services and supports and really rebalance the provision of those services from institutional settings to home- and community-based settings.

We are seeing some really good things happening in the demos right now around that. We have some bright spots. We've got health plans that are transitioning large numbers of individuals out of nursing facilities back into the community. We also see really great relationship building between community-based organizations and health plans. So we've seen the Alzheimer's Association training care coordinators in Texas and Rhode Island and California, really great collaboration between long-term care ombudsmen and nursing facilities. In Ohio, we've seen real improvement in the quality of nursing facilities, so some bright spots there around long-term services and supports.

But, by and large, the demos are not designed to better deliver home- and community-based services or even measure whether the health plans are successful in

increasing long-term services and supports and rebalancing that provision into the community from institutional settings.

The result of that is that we really see a lot of unmet needs. So we already have a healthier subset in the demo plans, yet we know that about a third have unmet need when it comes to long-term services and supports. They need more help with routine care, and that unmet need has dire consequences. We see social isolation, missed medication, missed medical appointments, falls, social isolation. That leads to increased hospitalizations and, of course, increased institutionalization.

Really, none of the plans are offering increased home- and community-based services. We see in Michigan, there is a waiver, an additional 5,000 slots, but that's been really hard to access. And then some plans are providing these optional benefits, but what we've really seen is that that's not happening. But it's really hard to ascertain whether that's happening because we're not really looking at that in the demonstrations. We're not evaluating whether we're connecting people to long-term services and supports.

So we did a Public Records Act request in California to get that data, and what we found is that the health plans referred fewer than 1 percent of its members to our adult day health care program, slightly higher for our personal care assistance program. For those optional home- and community-based services benefits, aside from a few outliers, most of the plans aren't providing any of those optional benefits, mostly personal emergency response systems, which are helpful, but that's not really what we're getting at there. We're trying to rebalance care, and that's not going to do it.

So we have recommendations on this. We think that it's really important to measure how plans are doing on rebalancing. So we really need to know how many people are being referred to long-term services and supports, what kind of optional services that are being actually provided.

And then our second recommendation is that the theory that health plans would invest in the short-term and long-term services and supports in order to save in the long term has really not borne out. What we need are the benefits to be required as part of the benefit package as a required benefit and part of capitations or funded through

some other sort of design, either through in lieu of services or something else where the health plans are actually being compensated for these services and that they are required and available to all members, otherwise they're not going to happen.

And, finally, I'll turn to the lookalikes. Yay! Two minutes. I'm also a fast talker.

So the lookalike plans are Medicare Advantage plans, but they're being predominantly marketed to dual eligibles, and now those enrolled in those plans are predominantly duals, over 70 percent.

The problem with these is that they are not integrated, nor are they regulated. So unlike dual special needs plans, they are not subject to any of the integration or special requirements that you would want to see for the duals population.

So we think that this is a major step backwards in terms of a plan offering, and that it's not really a choice at all. We really actually see this as a consumer protection as by regulating these lookalike plans because they're misleading and they're not actually serving dual eligibles. Evidence from on-the-ground advocates find that

that can lead to lack of access to benefits, particularly on the Medicaid side and improper billing.

So we recommend that CMS limit the marketing of these plans to duals. We also recommend that they treat any plan that has an enrollment of duals that exceeds 50 percent as a D-SNP and be regulated as a D-SNP.

Then, finally, CMS could also require that any plan sponsor seeking to offer an integrated product, like a demo product, for example, must agree in its contract not to offer a non-integrated plan in the same service area that serves 25 percent of dual eligibles.

So, in conclusion, we think that improvements to the demos should focus on policies that target improving the delivery system.

Duals are experiencing a wide array of issues as they are living in poverty. In a person-centered design, we must recognize that a delivery system built for this population will look very different than other plan offerings and designs. Our policies, therefore, should target ways we can improve the system rather than eroding consumer protections and restricting beneficiary choice.

Thank you.

* DR. MYERS: Good morning. On behalf of my team and our patients, I just want to say thanks for having me. My name is Griffin Myers. I, along with two folks, started an organization called Oak Tree Health about seven years ago, and the mission of that organization was to rebuild health care as it should be. And that for us means personal, equitable, and accountable.

I included some background materials for you, but I think in terms of sparing sufficient background today, it would be helpful to talk about what is possible when you have a provider group that is truly aligned with a managed care plan in the care for dual eligibles.

To do that, just a very quick sort of background is that we are a value-based network of primary care centers around the country focused largely on communities where duals live. So about half of our patients, a little under half are dually eligible. The other half are Medicare and pretty close to qualifying for Medicaid.

We take care of about 50,000 people in 47 locations in seven states, and the objective is to use an evidence-based, team-based model, combined with population health analytics and a whole bunch of technologies and

workflows that help us take variation out of the care model and deliver that evidence-based care to our patients.

It's a fully employed model. We have about 200 licensed providers who take care of our patients, and we think about it as primary care with a capital "P." So that includes primary care but also pharmacy, psychiatry, behavioral health, social work services, and in addition to that, we have what we call our community engagement model. Every one of our centers has a community center to help address all kinds of needs in the community, but also includes things like transportation, on-site patient relations.

And I say that because this is a model that works within a managed care structure. All of the things that we're talking about today require us to work in partnership with a health plan.

And there are two reasons that that's become important to us, but mostly important to our patients. Number one is around the way that we coordinate with plans and share data, and the second is around our ability to enter into value-based contracts.

Generally speaking, for all of our patients, we

enter into value-based, globally capitated, what we call "full-risk arrangements" with our health plan partners, where we are now responsible for everything that happens across the continuum of care. Frankly, as we say to our team, keep our patients happy, healthy, and out of the hospital.

Without going into too much detail into our care model, think about it this way. We build an empty building in a community where we don't know anybody, and we spend a lot of time educating the community on primary care, what it is, how it works, Medicare, and Medicaid and their benefits therein, that we accept those things.

We do a really substantial intake and structured geriatric assessment, a whole lot of risk stratification, have a longitudinal primary care model, a lot of population health management that our teams work through, including a whole bunch of additional population health interventions, including behavioral health, pharmacy, things I mentioned before.

And then when our patients do require services outside of our primary care centers, we call that "care navigation," and we support them going to the specialists,

getting an image or a diagnostic, being in the hospital in a post-acute setting.

And I share that with you because I think the results of that are really important. People often say to us that nothing you just said sounds like rocket science, but it seems to be working. And I think part of it is because it is what's possible when you put a structure in place.

So to give you a little bit of information on the patients that we take care of, the median age is 69. That ranges from 20 to 103. About 23 percent of our patients are under 65. The rest are over 65. Forty-two percent of our patients are dually eligible. Average income for the whole group is about $21,000 a year.

And in terms of the epidemiology, about 35 percent have a behavioral health diagnosis, so about 17 percent is substance-dependence diagnosis. About half have an adverse social determinant, largely in the form of housing, food, or social isolation.

I share that with you because when you apply this sort of care model -- and we've done this now, like I said, in 47 places around the country -- we've seen about a 41

percent reduction in hospitalizations, and it's those savings in the Part A spend that allowed us to invest in what we do, continue to grow. That comes with about a 43 percent reduction in emergency department visits, and in tenured patients, folks who we've had the opportunity to care for them for 12 months or more, five stars on the HEDIS Quality Metrics.

So I share that with you because, as I thought about preparing today -- and there have been a lot of folks on the team who wanted to share these -- we thought about what would be most helpful, and where we uniquely can share is that we build relationships with patients. We have responsibility for them and actually take care of them. I thought the best way to explain that would be to share a little bit of a story.

So, on Wednesday afternoons, I still have the privilege of taking care of our patients. I don't have a panel of my own, so I fill in when they need me. And I'm there on Wednesdays and do the problem visits.

There was a gentleman, an African American gentleman named Thomas from the South Side of Chicago, who came and established care with us in 2016 in our

Bronzeville Center. If you know Chicago, that's at 43rd and State. It's a great neighborhood but it's had a lot of challenges over the last couple of decades.

He came to us with a history of chronic hip pain, obesity. He had been homeless virtually his entire life, and interestingly, when you shake his hand, he had had a finger removed because he had to have it amputated for frostbite.

He was a former and current cocaine user, something he wasn't proud of but he had been working on, and when he met us, he found that we accepted these other plans and signed up for a D-SNP plan.

Pretty early on -- I didn't meet him until later on in his course, but our care team got started taking care of him, and he got his pneumococcal vaccine in 2017. We screened him for hepatitis C. It was found that he has chronic hepatitis C, and he had an elevated PSA.

I met him about a year and a half later in March of 2017, and I remember when I met him because he was born in the same week as my father in 1951. I was just covering that day for the medical director, who had other duties, and so when patients need to be seen, I'm there.

He came in with a pretty unique story in these settings, but in his life -- and as you may have heard, I'm an emergency doctor, so we see this quite a bit in the emergency department. But he was trying to get into a shelter, and the shelter wouldn't accept him that night because he had a cough. And what they presume when you have a cough is that you're contagious, and so you need to go see a doctor, get a prescription, and get a note to prove that you're not going to get everybody else sick.

So it's not advanced medicine by any means, but we had the conversation. Interestingly, he was able to, rather than go to the emergency department, call us, come see us same day. A van brought him over. I saw him as a walk-in. He got his prescription. I gave him my cell phone number. We wrote everything down on the form. He got a ride back to the shelter. I called just to make sure, and sure enough he got into the shelter that night. That is, by no means, a hero's work. It is just like the basic thing of being available to him when he needs to.

Well, about a year later he transitioned to another one of our centers that had opened on the west side of Chicago. It was closer to a shelter he liked. In

reviewing his chart in 2018, he was treated with Harvoni, which is one of the notoriously expensive hepatitis C drugs. It was later found to be nondetectable. So we, and the scientists who developed that drug, cured him of his hepatitis C.

He had a really long series of conversations with his care team and completed an advanced care plan, and then earlier this year, despite everything in his life going on, he was actually able to get a colonoscopy, which showed he had polyps, and we are going to follow up on it.

But the story this summer changed a little bit. That elevated PSA, which we knew and had been following, he actually had prostate cancer, and he had been receiving pretty aggressive oncology care, and he decided he wanted to change the way things were going. Later on he was found to have metastatic disease, had a tumor in his spine that weakened the bone. He ended up having what is called a pathologic fracture, due to the tumor. His bone had a spinal cord injury and he was paraplegic, and he moved into a nursing home with our support.

And he came in last month, and sure enough the care team did his annual visit. He got a flu shot this

year, but was transitioned care from us to the PCP in his long-term care facility.

And I tell you that story because I think it highlights a lot of things. First of all, it highlights the work that our team, as so many great primary care doctors do in our community, care for our patients, and highlights our mission at Oak Street and the core tenet of equity being part of what we do.

But I also think what is shows is that in partnership with a health plan and an enlightened primary care group who wants to do the right things, all of the challenges that our patients have, we are still able to do all of the evidence-based stuff that you want, whether it is in the best neighborhood in America or one with a lot of challenges. In reviewing his chart, this gentleman, over the time he was with us, had annual screenings for fall risk; hearing loss; advanced directives being put in place; alcohol abuse; substance abuse; cognitive decline; depression, which was negative; a vulnerable elder survey, which is a functional survey. He got all of his vaccines and virtually every single one of his stars or HEDIS gaps was addressed.

And I share that with you because I think it gives us an opportunity to have a conversation today about a lot of things, but one of the challenges that we face is we were doing all of these screenings and all of these care gap closures in a gentleman who had a lot of challenges, in a population that has a lot of challenges. And while I know there has been some progress made, the best way to have a high stars score in these communities is to avoid them and to go to communities that don't have these challenges, where you don't have adverse social determinants, you don't have high acuity, you don't have poor access. And that is not what we choose to do.

But I share that story with you because I think there is an opportunity. Really, it's a pass-through to us. But we know that there are a lot of plans that I think would want to invest in these communities. Stars scores affect not only their quality rating on the internet, and what brokers have to tell patients. They also affect the rebate and reimbursement, and, therefore, the incentive to invest in these communities.

And I think there is an opportunity for us to do better, namely to risk-adjust these measures in a way that

they reflect the underlying demographics, the social determinants challenges, and, frankly, the location of the communities.

That is a lot else we could talk about. I am certainly interested in other perspectives. We would certainly have different perspectives on enrollment, on attribution, on some of the lookalikes. But I wanted to tell you that story of Thomas and of our team, because I think it reflects what is possible in these models in partnership between a primary care group and a payer, with shared values around taking care of dual eligibles. So thank you.

* MR. MONSON: Well, thank you. Thank you for having me this morning. It is a true honor to be here today with -- it is always fun to be in a room of people who care passionately about Medicaid and dually eligibles, because we don't always get to do that, so that is fun. And I am honored to be with such esteemed colleagues on this panel, and thank you to the MACPAC staff, and I think Kirstin, for arranging everything today.

So I was asked to come today to talk about a health plan perspective on dual integration, and I think it

is important for us to start with something that our CEO always tells us, which is if we do what's right for people, and we advocate for good policy, everything else will fall into place. And that's why we care about dual integration, because it is good for people and it's good policy. And the reality is, it works. We have seen improved quality of care, we have seen improved beneficiary satisfaction, and we have seen lower costs to the overall system.

I think it's really important to just spend a couple of minutes talking about some of the national results about various integrated programs. In California, the Financial Alignment Demonstration, there was a beneficiary satisfaction survey that was put out by the SCAN Foundation in collaboration with UCSF. We saw 27 percent of members. They reported an increase in quality of care versus a control group. Only 26 percent reported an unmet need, which is too much, agreed, but versus a control group of 43 percent reporting an unmet need. And members reported that they are significantly more likely to get all the help that they need.

The CAHPS scores, nationally, for the demonstrations, had been rising year on year. For those

that rate their health plan as being satisfied with their health plan, 9 or 10, which is the highest score, is now at 60 percent. If we look at the quality outcomes themselves, in Ohio, in the demonstration, 21 percent decrease in inpatient utilization, 15 percent decrease in SNF admits. Same in Illinois, 9 percent decrease in SNF admits.

The MSHO program in Minnesota, which is not part of the Financial Alignment Demonstration as an MMP but as an integrated program of the FIDE-SNP, 48 percent less likely to have a hospital stay, 6 percent less likely to have ED visits.

So these programs are working on a national scale, and we see this ourselves. So we have the good fortune to operate MMPs in six states across the country. We have nearly 50,000 individuals who we have the honor of working with. When we survey our members on satisfaction, we have actually seen higher satisfactions for those who are in the MMP programs versus our Medicaid ABD programs or Medicaid LTSS programs.

And then in our quality results from January of 2015 to January of 2019, across all of our programs, excluding California, we have seen ER claims per thousand

decrease nearly 24 percent and inpatient claims per thousand decrease 30 percent.

So these programs are working. They are also a normative good. These are good programs for people.

One of the things that we see that are working in these programs, that are driving some of these results, I will pick up on some of the things that both Amber and Griffin have talked about which is it does provide an opportunity to collaborate across the system. It gives us, as a health plan, the opportunity to see all the behavioral health, all the physical health, the LTSS services, and our pharmacy services, all together in one holistic view. It gives our care manager and the team that works behind her the opportunity to do that.

So in a similar story -- and we did not actually collaborate on this -- we had a member who was homeless. He had broken his ankle in six places and had surgery. So our care manager went and visited with him in the hospital, to help develop his person-centered plan. He did not want to live in a homeless shelter anymore. Unfortunately, this is an individual with substance use disorder, so he was not able to get a permanent house.

So we helped, first of all, discharge him into a nursing home so he could rehab. Obviously nursing home, not a place that we would prefer to have him go, but an opportunity for him to get the rehab he could get, which would be tough for him to do in a homeless shelter.

Then he was discharged to homeless shelter, where our behavioral health case manager, our nurse case manager, and the case manager at the homeless shelter collaborated to make sure that he got the therapy that he required, he got SUD counseling, and went to self-help meetings. He got sober, he got permanent housing from the local housing authority, and was actively looking for a job.

These are programs that would be very difficult to do outside of an integrated environment.

What are the other things that we see that help as being part of an integrated product? There is a single point of contact with the plan. So individuals who are in the fee-for-service system, honestly, they don't know where to go. They could go anywhere. They are being pulled in many various different directions from a variety of providers. Potentially individuals who are in multiple plans are being pulled from multiple plans. Here, they

have one person to go to, their care manager. They get one ID card. They get one EOB. Providers have the opportunity to provide one claim. It makes it easier for them to bill.

And then, importantly, because we have the physical health dollars from the Medicare side, which folks in this room know that this is one of the core problems with a dual eligible, is that the work that is done on the Medicaid side may lead to benefits that accrue to the Medicare side. Because we are able to have those dollars, we are able to invest in innovation. So we have passive sensors that we have deployed in individual's homes, with their permission; palliative care programs. We have automated pillbox. We have been training personal attendants to observe changes in conditions and alert us to those. We have been able to do value-based arrangements with nursing facilities to align on the right incentives on key quality measures like hospital readmissions and short stay community transitions.

So what are the types of things that we think would be good to export from the Financial Alignment Demonstration to other dual plans, or to make sure that we broadly use? One is the contract management team. This is

a little bit technocrat-y -- okay, I didn't say that right, but a little bit of inside baseball, if you will.

But this is where CMS, both the duals office, MMCO, as well as the regional offices, as well as the state Medicaid departments and the health plans, all get together on a monthly call, or in the early days, more frequently than that, and have an opportunity to talk about what's working, what is not working, and problem solve. And because these programs are disintegrated, that opportunity to work collaboratively is very important.

Passive enrollment has been a critical role in order to make sure that we have enrollment in these programs. We know, from behavioral science, that people tend not to choose things, but they will stay in things if they have an opportunity, and they have an opportunity to leave. And what is interesting, as we have seen in our own data, that those who voluntarily enroll versus those who are passively enrolled, by month nine their disenrollment rates look the same. So once they have had an opportunity to see what the program is like, those who are passively enrolled do stay for the long run.

Member and provider advisory boards. This is a

best practice inside the Medicaid program, but doesn't necessary exist in the Medicare program, and through this opportunity we get to put that for both. And this is an opportunity for members to speak about what they want in the program, and providers to have a voice as well.

Independent enrollment brokers. These are individuals who have nothing to gain outside of helping an individual pick the right plan, or not plan for them, or other program, like PACE. This is a critical role to help beneficiaries make what can be a complicated decision.

Not to be understated, but the shared savings that accrue to states. In each of these programs there are savings that come right off the top of the program. It can be up to 6 percent in places. And this happens for both the Medicaid side and for the Medicare side. But this is the way the Medicaid side and states get to share in the savings from what is working well in these programs. Those rates, if you took those savings right off the top, would not be allowed in a straight Medicaid program because they would not be actuarially sound. But here they are allowed. This is a way to essentially move money into the state's hands.

Deeming was mentioned already so I won't belabor that point, but also the alignment. One of the best practices we have seen is in states like Ohio that are fully aligned, their Medicaid programs and their Financial Alignment Demonstration. So on the Medicaid side, at least, it doesn't matter which program you are in, you are going to have the same experience.

So what are some of the major barriers that we are seeing to integration across the system, that are prohibiting these programs from moving more fully? Well, one is that it's an alphabet soup out there. There is D-SNP, HIDE-SNP, FIDE-SNP, PACE, ACO, MMP. Now there is PCF. There is going to be DCE. And the reality is, even for those of us who make a profession out of this, it's confusing, let alone for providers or, of course, most importantly, for beneficiaries. How do you make a choice across these various different entities that are talking and have various different incentives, and the programs are not aligned at all?

Additionally, we have enrollment challenges that happen, and those enrollment challenges are exacerbated by the alphabet soup. So we have PACE, that's able to

directly enroll individuals. There are the ACOs and Primary Care First, and now the DCEs as well, have auto-assignments, so beneficiaries are automatically signed and they can't leave the program.

On the Medicare side we have brokers who are obviously working, and the incentives of the brokers are not always aligned to ensure that individuals are in fully integrated programs.

And then we have federal policy, and on the federal policy side we have some good policy that came out in the last few years around default enrollment. So now if you are newly eligible, if you are in a Medicaid plan and you are newly eligible dually eligible -- say that 10 times fast -- you are default enrolled, in states that adopt this, with plans that are prepared and have gone through the right reviews. You are then enrolled into the companion D-SNP that exists for those individuals, so you have the opportunity for integrated enrollment.

However, if states tend to move, states decide they want to move to a Medicaid MLTSS product or to a Medicaid ABD product for dually eligibles, and those eligible have already been existed, they don't have the

same rights that those who were default enrolled as a new eligible do. And so there is opportunity for us to ensure that everyone is treated equally.

Ultimately, what I would say is these are good programs. They are good for people. They have outcomes that are not only trending in the right direction but are showing that they are working. Beneficiaries are satisfied and they are helping the overall system. And we are proud to be participating in them, and we look forward to working with all of you to help grow these programs as we continue down this path.

CHAIR BELLA: Thank you, all. Sheldon?

COMMISSIONER RETCHIN: That was a really terrific panel. Just each of you provided so much color for me, anyway, on integrated models, from different perspectives.

I have a question, I guess, for Dr. Myers, and then I want to maybe make a comment and commend something. I actually think I will write to Tim as well.

First, I wanted to ask you -- and thank you for your case presentation. That was just really cool. And I will say a commentary on this. It is reassuring to me -- I mean, you're both in for-profits, right? I'm reassured

that there's a market there for for-profits and that you are motivated to do the right thing, and doing it.

I wanted to ask you, so your primary care physicians in Oak Street, what's the average panel size that they take? I'm going to guess 650, 700?

DR. MYERS: No. First of all, you can just call me Griffin. The second thing is, so average primary care panel size in this country -- and this is actually quite hard work in a fee-for-service world, because if you ask most doctors how many patients, they are going to tell you how many they have billed on in the last two years. But there is a gentleman at UCSF who has done this work named Thomas Bodenheimer, and it turns about to be about 2,500. Our panel size, at capacity, is going to be like 450, 500, something like that.

COMMISSIONER RETCHIN: 500?

DR. MYERS: Uh-huh.

COMMISSIONER RETCHIN: That's incredible. That's incredible. And let me just add to that. First of all, congratulations on doing that. You are bringing a model of care. And I'll say, the model of care you're bringing is amazingly similar to the concierge medicine, which takes

care of a very different population than you are.

DR. MYERS: Yeah. We talk about that a lot. That's not a term we use. We don't think that sort of reflects on what we are trying to do.

COMMISSIONER RETCHIN: I'm sorry.

DR. MYERS: No, no. I think you are right, and for what it's worth, we take a lot of pride in the communities that we serve, and I actually think if we headed up to the North Shore, we would take better care of those patients as well.

I would add just that, really, what allows the model to work, it's the same underlying payment stream. It's just paid in a different way. Like we don't thrive until after our patients thrive, and that price mechanism creates some discipline that allows us to invest in what our patients need.

COMMISSIONER RETCHIN: So that's a cool story. I just congratulate you on that.

So here's my comment. I was struck by actually both, or all of you, in terms of something you referred to, which is the art of choice. And so if you haven't read it there's a great book out by Sheena Iyengar from Columbia

University called The Art of Choosing and the science of choice. And it's not always intuitive. I think we have a choice problem here. Too many choices perhaps.

But I almost think CMS ought to bring in an expert body to better -- because we are seeing variations in different markets, and they are not explainable, in terms of the opt-outs. They are not easily explainable, not about penetration of MA plans in the states or regions.

And actually, in California, there is an interesting PhD dissertation that was done by a grad student at UCLA on this very issue, looking at brochures, and found that the brochures had not been translated for different ethnic groups. That's pretty basic.

But I do think that CMS ought to look at this. I don't care about the population in terms of literacy rate, no different than any other population. It's just too many choices and too confusing.

CHAIR BELLA: Kit.

COMMISSIONER GORTON: So I want to follow up on what Sheldon was talking about, and, Sheldon, you didn't do the movie reference, right? This is The Matrix. The problem is choice. Hell, go back and watch the movies,

dude, right? The problem is choice.

[Laughter.]

COMMISSIONER GORTON: And so I have a quick observation that I want to make and then I want to pose a question to the panelists.

My observation is that one could conclude, from Amber's comments, that if somebody uses their right to disenroll that that is indicative of an unmet need, and it may be. But people don't have to give the reason for why they are disenrolling, and I think it's important we all accept -- I think most of us in this room accept -- I certainly do -- as essentially an article of faith that integrated care is better.

I don't know that everybody else buys that. And one of the unidentified costs of integrated care is the issue of choice, because to get care properly integrated you have to sign up for a walled garden. You're signing up for a controlled ecosystem with limited numbers of choices. And I do think it's important to recognize.

My experience in Massachusetts was not that we couldn't meet people's needs in our MMP network, because we

did meet people's needs. What we couldn't necessarily do was address their very legitimate preferences about who they were seeing, or what the style of the care that they were getting. They had the right, under the Medicare fee-for-service program, to go anywhere they wanted, and sometimes our walled garden got in the way of that. And we talked about disruptions of care and other things at previous meetings.

So I think what I would like to know, if you all have any information, is on this more fundamental question of do beneficiaries and their families uniformly value integrated care? Do they? I don't know. I would like to know the answer to that. And if we think they do, then how do we know that? What are the data points?

We all have anecdotes where somebody will say, "Oh well, you manage my care very well." Beautiful stories, right? And anybody who does this work knows that you can come up with success stories that prove that at least in the individual case it works. But there are huge numbers of people -- I think Amber said in the statistic that even in the people who voluntarily selected their plan, 17 percent disenrolled. Why?

And I don't think -- and I am willing to be educated, but I don't think we have done enough work from the beneficiary perspective, and from the provider perspective, finding out why it is that when you offer somebody one of these beautifully orchestrated models of care, that they say "no, thank you."

So my question to the panel is, you know, how can we be sure that, in fact, we are offering beneficiaries a model that they would want to choose, or is the high levels, the moderate -- I don't want to characterize it -- are the levels of disenrollment, in fact, expressing an alternative normative value base -- right? Michael said, you know, with the normative choice this is better care. Well, you know, care is in the eye of the beholder, and I sort of wonder whether, in fact, we know what we are talking about.

And so I would like to know why it is, from an evidence-based perspective, that people think that people want integrated care, and if there is that evidence-base, what is it, because I'm not sure I have seen it.

CHAIR BELLA: Do any of you have a perspective on -- I'm not sure that there is an evidence base, Kit. I

think that's what we're highlighting. There has been a lot of work done about why people make choices or they make choices to stay or make choices to leave or make choices to go in, but I think it would be a stretch to say there's an evidence base, and that might be suggestive to us, something we could recommend or do more work in, is continuing to dive into why people are making choices in and out and around and all that sort of stuff.

But if any of you have a comment, feel free. Otherwise, we'll keep badgering you with more questions.

DR. MYERS: I'd love to just say one thing. I wanted to be an academic doc when I grew up, so having peer-reviewed evidence on this would be great. I have not seen it either. But I will give credit to a colleague of mine, Geoff Price, who has tried to understand this with us at Oak Street. The number one reason we find in talking with our patients why they don't choose to sign up is they actually don't know it's an option. We ask everybody after their sort of election is made during -- either in open enrollment or in this case a special election period, the number one reason, if they disenrolled, why they disenrolled, and the number one reason is they didn't know

they disenrolled. And the thing that we find anecdotally is that when patients especially in the duals program or in the integration models do disenroll, it actually comes from typically a specialist or -- and this is just to be very direct -- a specialist or a home health group saying, "You need to get out of this," because they don't want to deal with the oversight.

The other experience I can tell you is in 2015, when the program launched in Illinois, there was a dental benefit in the integration model that didn't exist in the traditional Medicaid model, and that drove a lot of behavior. Once dental was added and there was no differential sort of like benefit to your benefit program, people dropped out that way. But the number one reason is people don't know that they drop, and when they do drop, it's because somebody told them that they don't frankly want the oversight and don't need the plan.

MS. CHRIST: I'll note that the MedPAC report did show that individuals who opted out or who disenrolled did have those higher risk scores and were sicker. I don't feel like that's adequate, that's not getting to your point in its entirety, but I think it is important to note that

that was at least a data point around the characteristics of the population.

But I do think that there is this tension right between person-centered and what we think is best, right? And person-centered has to, if it's a foundational element, which I think we should be committed to, we have to recognize that an integrated system, regardless of how good it is, might not be the thing that that person wants. And that's important to recognize, and it feels really paternalistic to go the other direction. So that's where I'll leave that.

MR. MONSON: So I fully agree that we wanted to be a person-centered system. I also think that we can't ignore the fact that just because the existing system is where you start from it's a better system. And I think -- I don't know if anyone would actually say that the existing fee-for-service system is person-centered. And I would just echo that we don't have the evidence base, but there were many, many instances and stories of specialist providers, nursing homes, and home health agencies and others who would call up the independent enrollment broker and say, you know, "I've got 100 people here for you to

disenroll from this program." And that's because for a whole bunch of reasons that they did that. So I don't -- I'm not sure if we can say that everyone who left the program, even though they may have had higher risk scores, that doesn't mean that they made an active choice to leave. It could very well have been that they were captured inside a system that made sure that they couldn't get out.

DR. MYERS: And I hate to add one other comment, but I just think the risk score thing is really interesting. I did not know this going in and have since sort of developed this -- we developed this sort of understanding over the last seven years. Patients with higher risk scores definitionally are receiving more care, and the walk-in-off-the-door risk score for our patients in Bronzeville where I see patients when they're brand-new is way lower. And that's still a patient population in that center that's about, let me guess here, but around 80 percent dual eligible in that center. And if they come in and then they leave, they are not healthy, but they have had such poor access that it doesn't look that way. So I just am always cautious with our teams about interpreting risk score's acuity, like there's a correlation. But not

to be too -- like the first derivative of risk score is actually what tells you where somebody is in their care journey.

CHAIR BELLA: Martha, then Bill.

COMMISSIONER CARTER: I'm kind of working on a theme, and I want to make maybe a more active question to you. So just in the 65 and older population, that's a 30-year or so span of age, and so we know that the intellectual and physical capabilities are much more important than the age. And then sometimes you're working directly with the beneficiary, and sometimes you're working with their baby-boomer children. So my question is: How does a plan structure -- reach out and structure enrollment materials for this extremely varied population? And how do the plans and providers make sure that the information is getting to the people, the right people who could actually use it? We've talked about disenrollment, but I want to look toward how do you actually do this well. Do you have any tips on how to reach out in this, like I said, extremely heterogeneous population?

MR. MONSON: I'll start. First of all, the materials are all model materials, and they all have to be

approved by the CMT. So these are all materials that -- they're standard materials that everyone gets at regular intervals, and those are essentially basically the same across everybody, with some maybe minor modifications.

There's two challenges, I think, inside of what you're saying. So challenge one is there are people that we don't know where they are and cannot find them, right? And so there's a whole series of activities so that -- and, in fact, the state doesn't know where they are and CMS doesn't know where they are. So we get contact information. That contact information is out of date, is what it usually is, because, you know, they may have been staying with their aunt and now they are now living somewhere else, with their cousin, for instance. And so that is a harder problem to solve, and there's lots of activity around using other databases and using prescription information and kind of last visit information on the provider side, and, actually, MMCO was really helpful early on in the demonstrations in providing Medicare files to us so we could have that information. So that information now flows as we get newly eligible.

The second issue I think is around, okay, so now

I've got someone, and what's their preference, right? Who do they want to be a part of their care team? And that's part of what we do on intake, effectively, which is we meet with the individual to ask them and understand who is it that they want to be a part of their care team, their circle of care, and then that person and that group is included. Sometimes it's a family member, and sometimes they don't want their family member included. And it could be others from their community. It could be their providers. But those are actually all well spelled out inside the contracts, and those are things that we are held accountable to by our regulators.

MS. CHRIST: I'll add that some best practices around kind of creating materials and outreach to individuals to describe these types of integrated plans is through really strong relationships with community-based organizations that are trusted, and that's going to serve that wide array, that diverse population that the duals represent. And so it really is, I think, incumbent -- and I think we've seen this. I always say that one of the biggest highlights of the duals demonstration is the wide collaboration we see across the spectrum, particularly with

community-based organizations, with, you know, meal delivery and senior centers, you know, anything you can possibly think of. There are all these collaborations happening, and that is the real -- the strength there. And I don't want to use another movie reference, but I will. With "Field of Dreams," though, I think as you were saying that, the current system obviously doesn't work that great for people. But they think it is, or at least they're very comfortable with where their providers are. And I think if we would, you know, build it, they will come. You have to prove that this is something that would work for them. It feels very guinea pig or untested to force folks into the plans that haven't proven the results. And I think as those relationships build -- and I think we're seeing this. I think we're seeing these positive trends upwards of satisfaction and better outcomes because the relationships are getting built.

And I think in Texas, it was, there was really dedicated work on building those provider relationships because, as we've heard, providers just weren't on board, and there wasn't a lot of work to get those providers on board, particularly in certain communities, those serving

ethnic and racial groups, just the work wasn't put in, and that's where the work needed to be done. And we saw the outcomes of that, that there was no participation from those groups.

CHAIR BELLA: Bill.

COMMISSIONER SCANLON: Thank you very much. I thought the presentations were tremendous. Payment has come up a couple of times in different contexts, and I wanted to sort of put out the hypothesis that maybe we're impeding sort of the success of this effort by not paying well enough. By "well enough," I mean calibrating payments appropriately either to individuals' needs or in an ideal world to their outcomes. I'll worry about the needs first because I think that's a lower bar, but it's still a very sort of important bar.

On the Medicare side, it's been over ten years, and we're happy with ourselves because we moved from demographic-based risk adjustment to diagnosis-based risk adjustment. But since then we've done -- there's research been done showing that among people with the same diagnosis, there's huge variation in terms of their, in some respects, health status and their use of services.

And that's not being taken into account.

On the Medicaid side, I actually don't know sort of what risk adjusters might be being used in these programs. So the question is whether there are models there that we really should be embracing and encouraging sort of wider diffusion. Or do we also need to be thinking about there, sort of how to identify the people that we need to invest sort of more funds? And I think this has potential impact for plans' participation, for plans' behavior in terms of how they serve individuals, plans' capacity in terms of how they're able to serve individuals.

So to me -- and I'll confess I was trained in economics, and so if you think about money driving everything, it's this question of do we have to get the payment right first before we can realize the expectations that we have for this type of an effort.

MR. MONSON: So I'll start. So I do think there's a couple pieces. The first thing I would say is that one of the challenges we can see with -- this is a heterogeneous population. However, depending on how the program is structured, it can become less heterogeneous. And so if we looked at -- so, for example, in

Massachusetts, the early days of the demonstration where it was only individuals under 65 in the program, so that's a very different population that the HHC scores actually don't particular account for well. And so there had to be adjustments that were made as a result of that on the Medicare side.

On the Medicaid side, there are pieces of the Medicaid side that actually live inside the demonstration, so programs -- the states where they had MLTSS programs in particular, they're using some of the rate structures they had that incent behaviors around transitions -- right? -- which we all want to have happen. But I would say there's a bigger point that's not about what's happening inside the demonstrations themselves, but across the alphabet soup. There is regulatory arbitrage and pricing arbitrage that can happen across the alphabet soup. The pricing is not consistent from program to program. So depending on where you are, a PACE program can be much more munificent to an operator than an MMP. Depending where you are, a Medicare product could be better than an MMP. And there are variants, obviously, all across that.

And so I think the real issue is less about rate

structures inside the demonstration than the fact that there is a proliferation of different rate structures that rent seekers can take advantage of.

DR. MYERS: For these value-based models to work, there's sort of two core components. The first is prospective attribution -- you have to know who your patients are ahead of time -- and risk adjustment. And as an emergency doc, I think risk adjustment is as important in terms of health equity as EMTALA is, which is the rule that requires when somebody shows up in our ED, no questions asked, we're going to take care of them.

I had a research associate within the last six months pull all of this stuff and look at the R-squared over time of the risk adjustment model to what the spend is, and it's actually substantially improved over time. It's by no means perfect, and I wish I could remember exactly what the current latest R-squared was, but it's better over time. I think the challenges are there are definite problems with coding intensity that we know happen, and, frankly, I think we've made a lot of progress, frankly, as taxpayers like seeing those policies come to address coding intensity. We do need the model to reflect

more social determinants and lastly to reflect more of the nonlinearities, like having diabetes and renal failure separately is not as bad as having them both together, and those nonlinearities are just beginning to be reflected.

But I do think ultimately more accountability pushing that down is going to require more risk adjustment, and I know there's a lot of people trying to get that right. And what I'll say is as a group -- and I'm sure there are some of my colleagues who would be frustrated by the amount of work this comment would create for them, but over time this model needs to get more accurate and more specific over time, and a good, high-quality practice should be able to do that. This is clinical documentation. We should be able to do that iteratively over time in a way that is accurate, specific, and reflective of the underlying disease burden of the population.

CHAIR BELLA: Chuck, and then I have some questions, and then anyone else, please raise your hand.

VICE CHAIR MILLIGAN: I want to thank all of you for what you've contributed, the preparation, the travel, what you've shared. So thank you all for offering that to us.

I have two questions. The first one, Amber, is for you, and the second one is for everybody.

I'm curious if you have a perspective on whether partial duals should belong in a D-SNP, and I've seen instances in which a D-SNP, by doing health risk assessment, data mining, can identify a partial dual who would qualify for Medicaid LTSS under the higher income standards for 300 percent of SSI, that kind of thing, as a feeder into getting a waiver slot, for example, but at the same time they're not in an integrated approach as a partial. And based on your comments both about LTSS and your comments about D-SNP lookalikes and kind of ways in which integration is avoided, I'm curious whether you have a point of view about whether partial duals should have access to a D-SNP.

MS. CHRIST: That's a very good question. I haven't -- my colleague Georgia has given this a lot of thought, and I have not. You could see where a partial dual just doesn't have -- a D-SNP model doesn't -- it's not really effectively serving them in the same way because there's not the integration on the LTSS side. You could see where a Medicare product that is focusing more on duals

because a partial dual is still going to be an individual who is going to need -- they're still fairly low income, probably going to have a lot of the similar needs as a full dual, where maybe a duals product plan could be better. But the really critical part is that integration across the spectrum, and to the extent that we're calling D-SNP alignment integration, I would say that in a full dual plan that it wouldn't make any sense, but in a D-SNP across to a Medicaid plan, a partial dual in a D-SNP, I could see more benefit there than inside of the financial alignment, obviously. Yeah, that's all I got.

VICE CHAIR MILLIGAN: So my second question, I want to go back to the choice issue. I want to frame a question slightly differently, though. And passive enrollment is the question. And so I want to frame up kind of a version of this for each of you and kind of go where you go with it.

Amber, for you, if the D-SNP had -- it was a PPO model with out-of-network provider access in such a way that the beneficiary would have choice of providers, if not, they're in a D-SNP. Would that alter your reluctance to support passive enrollment? Let me frame the question

for the others as well.

Michael, for you, kind of the slip side of that, which is if the D-SNP was more of an HMO closed network type model, would you have more concerns about passive enrollment as a form of potentially displacing a member from maybe their historic or traditional providers or not?

And then, Griffin, I'm curious. You've mentioned attribution a few times, and I am curious in terms of how Oak Street approaches this, whether the health plans that you work with are HMO model D-SNP, PPO model D-SNP, and if it's more PPO model, how do you deal with the fact that the members panel to you are kind of variable based on some kind of attribution logic. So I'm curious about the intersection of the enrollment rules and the network choice. So away you go.

MS. CHRIST: Yeah. So passive enrollment, not all passive enrollment is equal. I think the demonstrations used to be kind of the most -- I don't know what word to use -- extreme version of passive enrollment. But you could see passive enrollments that we're seeing, that's kind of happening now when someone becomes newly Medicare eligible and being passively enrolled into an

integrated plan. That looks different, right? Because the relationships with the providers haven't been established. And so to your question about does that look different if the provider choice is more free, and I think it does. I think, yeah, they're just not all created -- all passive enrollment is not created equal.

As a consumer advocate, I'm not willing to entirely concede. I'd want to keep passive enrollment off the table entirely. But I do think that in terms of kind of a spectrum that we're more comfortable with the more choice that there is for the consumer.

MR. MONSON: So I think it's instructive for us to think about the Medicaid program. I mean, this is MACPAC. So let's talk about straight-up Medicaid, where there's auto-assignment. In states that have chosen to go to managed care, which is a separate conversation, but in states that have chosen to go to managed care, those states under CMS supervision and guidance ensure that there's robust, adequate networks.

And I'm confident that we could argue on the margins about where there should be improvements to that

made, without a doubt, but I think that that is instructive, to answer your question about HMOs, because those are all HMOs, which is that with the right regulatory frame, which by the way includes the ability for plans to use single case agreements for individuals who maybe they really do need to see a particular specialist that they can only -- that person is the only one that has worked with them. It's taken them years to find that specialist, and if that specialist is willing to contract with us, then at that point, we can make that happen.

So I do think the question we have to think about is how do we ensure that we build a regulatory system that protects people in an environment where they're already auto-enrolled on the Medicaid side and then learn the same lessons and bring them to duals on the Medicare side.

VICE CHAIR MILLIGAN: But, in fairness, for duals, they're getting primary care for Medicare. So the auto-assignment plays out slightly differently in terms the physician, access to physicians they might have traditionally seen, right?

MR. MONSON: Yes. But a dual could very well have been a straight Medicaid individual for many years,

for two years, right, potentially? Or depending on who they are, it could be longer than that.

I understand the point, and I think we want to make sure. But I think the point really is that the networks need to be adequate and sufficient, and that is a regulatory question. We are responsive to our regulators. The rules are set, and we work with those rules. And we are held accountable to those rules as an industry. So if we don't think those are adequate networks, that's a separate question.

CHAIR BELLA: Griffin, do you have comment?

DR. MYERS: Sure, quickly. This is interesting because I don't know where you personally would come out on the PPO or HMO thing. I think we think about it very differently as consumers of our own products and for our patients, but there are really good reasons for an HMO, that I had my own mind changed.

These networks are very thoughtfully coordinated by health plans in two ways. Like the bad people are kicked out, and the good people are added back in. And there are good reasons to not be in an HMO, but they're pretty rare. If somebody comes to us and wants to sign up

for an HMO but they have an existing cancer diagnosis, an out-of-network oncologist, that's a good reason. That's pretty rare.

We had an experience with the attribution in 2015 in one of our states in the dual integration model, where in a very large, very urban county, were taking public transportation from the southern end to the northern end. It would take three hours. PCPs were chosen for -- and passive enrollment is something we feel really strongly about, in favor of, but people were then attributed after they were enrolled to PCPs on the other side of the county, which was a challenge.

And one of the things that we would say is where there is an existing in-network PCP relationship, certainly don't disrupt that. Where that doesn't exist, allowing the plans to attributes those lives to highest quality PCPs in the network makes a lot of sense.

But just to get directly to your comment about PPO and HMO, interestingly -- because we're a multipayer model, working 16 different health plans, our patients have choice. We want them to have that choice. A minority of our patients do choose PPO products. We actually do full

risk in the PPO products. Those patients are a little bit different, as you may imagine, just in profile, but it works in both models.

And I think the important thing to know is the value creation that we have in a PPO model is just less. Whether you measure it by reduction in hospital admissions, reduction in emergency department visits, lift in the Stars score, you just have less value creation in the model because you have less control.

I don't think what patients want once they have a high-quality PCP relationship, who is managing their care -- then they don't want choice. The problem is how do we give them choice to find that.

MS. CHRIST: I have just one follow-up comment. On the regulatory framework comment that was made, I totally agree with that, and an example of where that regulatory framework is not really great is California, which is sort of unique in this way. But it's a heavily delegated state, where plans delegate down to provider groups, full risk.

What happens when that occurs, both on the Medicare side for the Medicare plans and on the Medicaid

side, so if you're a Medicaid only, is that your network goes from the plan network that you think you might have access to, that your provider handbook that you get, that you could select any provider in there, but really that's not the provider network you have. It's been delegated down to a provider group. So you have providers now within this subset of providers, and that is a regulatory choice that has been permitted to stand. That just limits choice further and further for individuals who are enrolled into managed care.

So if you combine that with a passive enrollment process or any other sort of enrollment process, that people are not making those active choices, you really see a narrowing and a really erosion of complete choice there.

CHAIR BELLA: Okay. I'm going to get to go, and then Kisha, Toby, Sheldon.

Michael, starting with you. So getting very concretely, an opportunity that MACPAC has is to make recommendations, and as we look at how to make Medicaid and Medicare work better together, obviously with a focus on Medicaid, we're trying to understand how do we continue to foster integration.

So MedPAC did a lot in a June chapter that talked particularly about what do we do about these worlds where we have different organizations offering medical benefits and LTSS benefits and went so far as to ask questions about should that be allowed or should it be required that one entity or entities of a parent be offering long-term care and medical care in order to be able to serve this population.

So I'm curious, your thoughts to us on what this Commission could recommend that would further the ability to serve people in an integrated manner.

MR. MONSON: So the first thing is we could use a whole new title. I mean, the reality is that we have this environment because we've got two programs that don't work well together. They weren't designed to do what they're doing, and so that's a big ask, but that's a good recommendation. There's a way to do this that would be different.

I think underneath that, then, there is a lot of benefit to making sure that there's full alignment, and that individuals who are receiving particularly MLTSS services then have the opportunity to have an integrated

product.

So part of the thing that could be done is streamlining across all the programs, to move away from the regulatory arbitrage, so that that's a real recommendation that could be made, which is to say, okay, instead of having all these various different programs with various different enrollment rules and various different benefit packages, various different payment schema, have the ability for a state, because these base off of Medicaid programs, to choose what is best for their beneficiaries with oversight from the federal government and that has an alignment component to it.

I think that that would help move us in the right direction.

CHAIR BELLA: Griffin, my question for you is there's a lot of attention that happens sort of at the plan level, figuring out how do you have the Medicare plan and the Medicaid plan be the same thing.

You're underneath that, sort of raising your hand saying, "I want to serve these populations in a value-based way." Inadvertently, decisions could be made at how to integrate at the plan level that cause disruption at the

provider level. And I know you saw that a little bit in some of the financial alignment demonstrations.

So, as we think about recommendations, about how to make sure the medical side and the LTSS side are lined up, what should we be remembering from where you sit, so that we don't inadvertently do something that sort of knocks you out of that picture?

DR. MYERS: It's a really good question. From our perspective, I think there's just volatility in what we're supposed to react to. So once something changes, if we know we can build a program around it, that helps us. So consistency does help.

I would say on the way that we are treated -- because we work with the plans, I would say three things. Number one, having an obligate passive enrollment, where we know patients are going to be in and we can plan around that, we've actually built centers before based upon what was sort of released as a regulatory change in one of the dual models that then changed. And, frankly, it was a very challenging time for us, four or five years ago. So I think having passive enrollment and being that clear that those patients are going to be in that model we'll be able

to serve is important.

I think the second thing is attribution to PCPs happened in one case for us at the state level instead of being run by the plan, and the plan is closer to us, and what we'd love to see, they have the ability then to have continuity in PCP assignment, but also, then, when somebody does need a PCP assigned on quality -- again, this seems very self-serving, but we started with nothing, and now that we have a high-quality provider rating, the ability for people to send us patients would be great because 90 percent of our patients don't come to us that way. They come to us organically in our communities.

And then the third, I do think risk adjustment of Stars, and the only reason I say that is because that creates real challenges in access and the way the network is created for our patients, and it creates an investment in certain communities rather than others. Those would be the three things, and then as long as there's consistency on those, we're going to be okay.

CHAIR BELLA: Unfortunately, we can't opine on Stars, but one of our colleagues from MedPAC is in the audience, and I'm sure he will take that back. That's

outside of our purview, but we can talk about it, so thank you for that.

All right. Kisha?

COMMISSIONER DAVIS: Thank you for being here and sharing the stories.

I just want to go back to the lookalikes a little bit, and Amber, you shared some compelling recommendations for that. I just wanted to hear from Michael and Griffin how those lookalike plans impact you, for good or for bad, if you have any recommendations or things that we at MACPAC should be thinking about or recommending in that area.

DR. MYERS: You live this. From our perspective, having everything fully integrated is obviously better, but maybe I'm just not creative enough. But these plans are like designed as plans, and people choose them. So I don't know where we'd draw these artificial lines to sort of not have them be where they are.

I think what I'd love to see is just have the other models be so compelling that there's no reason to choose them.

MR. MONSON: So we have a lookalike, plan, so I will put those cards on the table. What I would say is

we'd rather not have one, but it is the market environment in which we live.

And I do think that there is an opportunity then to say -- and this goes back to treating the systems equally, and we want people to be in the most integrated environment that they can be in. Lookalike plans don't achieve that goal, but there is a collective action problem here that is a place for government to step in and say, "Duals should be in specific types of opportunities, and let's not have a flowering of others that create further disintegration."

CHAIR BELLA: We like to stay on time, but we have a few more questions. Can you guys run 15 minutes over, the three of you? Okay, wonderful.

Toby?

COMMISSIONER DOUGLAS: Thank you all for great presentations and all those great observations.

I want to go back to the issue on choice and the intersection with providers. Somebody mentioned the role that they play.

If you can talk about some of the best practices you've seen and ways of engaging providers and being more -

- seeing the value and support to help foster these financial alignment demonstrations.

MR. MONSON: So one of the things that was -- if you look at one of the most successful MMPs, at least by enrollment and also by some results is Ohio -- and one of the things that Ohio did, I think, that was very effective was they launched their Medicaid duals program roughly concurrently with the overall program. In fact, they call it one name. If you go into the state, they call it MyCare, and there's opt-ins and there's opt-outs. Opt-ins are people who not only are opt-ins but actually also are passively enrolled at state. So it's a little confusing if you don't live in that state.

But I think what was very helpful is they started -- everyone was put into the Medicaid side first, and it ran for -- I want to say six or eight months, and then the passive enrollment started. I would say that I think that doing one large wave of passive enrollment, not the best practice, as Amber mentioned before at that time. But I do think that that helped because it created this continuum. So some of the kind of concerns that happen from some of the providers and obviously from the members too were

allayed.

I do also think that the fear is that certain provider types fear that, "Well, gosh, all my patients are going to be taken away from me. You're going to empty out my nursing home. Things aren't going to happen," and I do feel like experiencing that the world will not end first is very helpful to that. And that helps on the nursing home side in particular. I think the PCP and the specialist side, it is about much more education, and explaining to them how this is not dissimilar, then, from being in a Medicare Advantage plan, which many of them have tremendous experience with already. But I think they just don't understand it.

I mean, the reality is often the typical physician doesn't actually understand what a dually eligible beneficiary is and what that means to them, both to them as a provider and to their consumer that is in their office.

So there's the fear of the unknown. So to the degree that you can provide more education up front, which is this is a version of Medicare Advantage, so if you're okay with Medicare Advantage, you're going to be okay with

this if you're a physician.

CHAIR BELLA: Sheldon?

COMMISSIONER RETCHIN: Thanks.

I do want to point out that Morpheus gave Neo the choice between the blue and the red pill, but there was no choice of no pill, just to clarify.

[Laughter.]

COMMISSIONER RETCHIN: I'm sorry. I couldn't leave that alone.

I wanted to get back to Griffin because I'm still enamored with the model, and I just want to point out something there. This is an independent primary care group, not owned or with a hospital. It's owned privately, of course, by private equity. But being independent is part of the secret sauce, and you must be getting either a sub-cap from the plans or you're just getting a downside and upside risk or shared savings. Is that how the model works?

DR. MYERS: The ideal model is full upside/downside risk.

COMMISSIONER RETCHIN: Full?

DR. MYERS: Yeah.

COMMISSIONER RETCHIN: Okay.

DR. MYERS: And sorry to interrupt you. That is the most common arrangement for us as well.

COMMISSIONER RETCHIN: Okay. So I guess I wanted to ask how actively you manage the members, those that you have attribution. You have somebody in ER, for example. Do you actively manage that person, or even more importantly, if you have somebody who needs an MRI or needs to be hospitalized, can you influence price?

DR. MYERS: So we actually just participate as a member of the network, period. Like we're going to pay whatever rates are negotiated. We're going to do those things now.

We are not a hospital. We can argue about whether that is a feature or a bug. I happen to think it's a feature. I know that there's a lot of people would say that you need to be fully integrated, but the problem is like, all right, we work with the hospitalists. Our nurses round on those patients. As an inpatient, we built a bunch of technology for our teams to round on our inpatients when they're not with us. We work super closely with our health plans. We know our patients and their families, and we see

our patients, on average, three times -- twice as long for three times as many visits in a year. So we're not afraid of that.

Really, the traditional model of this kind of management is this sort of hands-off IPA-MSO model, where I'm going to like pull the contract levers, and what's nice is you can get a lot of lives there, but you can be pretty shallow in how you can intervene.

We started on the opposite end. We started with a population of zero, but we're really intimately involved in our patients' lives and in their care, and we manage it obsessively. Because it's all employed PCPs, we do in-house ancillaries, and we work with our plan partners to get all of that data. And we're very protective of our patients. Because we're not bound by sort of fee-for-service economics, that means if our patients need something, obviously within the bounds of what we can do, we invest in those things.

But, yeah, we're very --

COMMISSIONER RETCHIN: Are you steering?

DR. MYERS: You mean in helping influence with low-cost preferred provider?

COMMISSIONER RETCHIN: Yeah.

DR. MYERS: So I guess what I would say is the overwhelming majority of the surplus comes from Part A. In our patient populations, there's really not a lot of savings in Part B because these are folks who actually need care they weren't previously getting, but they needed to be smarter. Like you'd rather them see a nephrologist and an endocrinologist and not a vascular surgeon for an amputation. Like there's still money in those things, but we do -- and I will say what's interesting is we certainly work with our plan partners because we participate in those networks. When you look at the Venn diagram, there's a lot of overlap, but they're not perfect.

Interestingly, where our teams tend to prefer for -- I think when you're largely talking about what it’s like for diagnostics and specialty care, the kindness with which that team and staff treats our patients and treats our teams is the number one input into where patients are going to go.

On the North Side of Chicago, for example -- I just remember this because I was involved in this -- there was an ophthalmologist who took care of a lot of our

patients -- we had no special arrangements or anything -- recognized that she was not in network and certain of the other networks. Her staff was great with our staff. Our patients loved her, and we said, "Hey, why don't we just send you all of our patients. Try to join these networks. We'll tell you the ones, the way it works."

People do this with their hands. There is no way to connect the pipes, so all the information flows. We literally faxed back and forth and called each other, and we have special phone lines and all this stuff.

In the long run, is this a piece of software you download from the app store? Maybe. But like for now, it's just build relationships and invest in what patients need.

CHAIR BELLA: Griffin, when you have a member or a patient that you have for Medicare and they're not in an integrated product but they have a Medicaid-funded need, how do you get that need met? Is it a noticeable difference for you as the provider when they're in like the Illinois demo versus when they're in a Medicaid fee-for-service program, or do you not notice that?

DR. MYERS: So if they are not in a managed care,

if they are just a traditional sort of dual eligible patient who does not have a managed care plan, then there's going to be a bunch of data that we don't get, for example. The example I always use is getting a census as a primary care doctor in the community to know which of your patients is in the hospital is nontrivial and requires plan input.

There's a bunch of vendors. You've got to have nurses calling the ED. You've got to have relationships at the emergency department and try to get all that together.

If you're a traditional fee-for-service patient without a managed care plan, we have no clue until you come in and tell us you were in the hospital, that you were in the hospital, and that turns out to be crucial because there's a whole bunch of stuff and activities that happens once we hear from you, once we hear from somebody that you're in the hospital. So it does make a big difference.

Once you're in with a managed care plan that has the infrastructure, which is largely going to be on their front-end review and all of those things, once you're in that, then we won't see that.

Now I will tell you that there are meaningful differences in the way that data is shared across plans,

and that just comes down to plan capacity or capability, really, but we don't -- again, like we want our patients to have choice, and we've built all the pipes on the back end to be able to make that work. But I don't want to say that everybody is equally good at it.

CHAIR BELLA: Brian?

COMMISSIONER BURWELL: I have kind of a similar question. So if you have a contract with a fully integrated plan, Medicare and Medicaid plan that covers LTSS, are you at risk for also the LTSS services?

DR. MYERS: That's a great question. We are not, and I think this is an opportunity.

And I had a conversation with one of my founding colleagues about this, where we think there's an opportunity to frankly allow the state to create some opportunity to participate in those savings if there's an integrated -- almost like a -- the term that we use -- and so don't lock onto this -- was sort of the side of like a "virtual PACE," where there's some way to put all that together, attribute someone the risk to that.

But, in general, only because we don't work in those facilities, those facilities typically don't -- their

economics are not built around sort of the value-based model that we operate. We don't. But I do think there's some opportunity in the long run to do that.

CHAIR BELLA: Amber, going back to the question about best practices with providers, did I cut you off on a response? Did you want to respond to that?

MS. CHRIST: Oh, I was just going to -- this goes back to a number of things, but Mike gives me this point many times about how there is different payment across these different plans. One of the reasons the lookalikes have proliferated is because they're getting -- not only are they not regulated, so they do not have to meet all of the regulatory requirements that you have to meet for a D-SNP or an integrated plan, which are heavy for good reason, but they're also getting more money for those members than the other products are getting. So they're financially incentivized in that way as well, which means that they can provide higher capitations to the providers, which means that they get to build these networks that are better, different, and bring in providers versus that money going to an integrated model to build those provider relationships and provide that flexibility in that funding

to the provider groups, where then you would have higher participation with providers.

And I am no rate expert or risk, but I think that that plays a part.

MR. MONSON: Can I just make one quick comment? Just back on the question about LTSS with physician services, I would just strongly caution here that it is really important to not medicalize LTSS in general. These are social services. These are about people being able to live a high quality of life. There has been a lot of progress moved away from it being medicalized, and putting it back into a physician's office, I think, would be moving us in the wrong direction. So I would just strongly encourage caution around that dimension.

CHAIR BELLA: All right. Unfortunately, we are at time because we could go on with you for a very long time. Are there any last words of wisdom from any of you to us? This is your parting shot. You've given us many, so don't feel like you have pressure to.

All right. On behalf of all of us, thank you for taking the time to be here with us. This is an issue that we're spending time on and that we think is very important,

and getting your perspectives was invaluable. So thank you very much.

[Applause.]

CHAIR BELLA: We are going to take a five-minute break which gives you about time to do nothing, but please try to come back in about five minutes. Thank you.

* [Recess.]

CHAIR BELLA: All right. If we could reconvene please. We are going to spend a few minutes then coming back to this topic of duals and integration, and then we will take a break for lunch. So I will turn it over to you guys. Thank you.

FURTHER DISCUSSION: INTEGRATING CARE FOR DUALLY ELIGIBLE BENEFICIARIES: PERSPECTIVES FROM BENEFICIARIES, PROVIDERS, AND PLANS

* MS. BLOM: So I think we are just mostly interested in any feedback you guys have for us about our continued work in this area. We are planning to come back to you in December with the results of some internal work that we are doing on this topic, but we are happy to take any other thoughts from the panel, or more, in general.

CHAIR BELLA: Sheldon.

COMMISSIONER RETCHIN: Yeah. Obviously I was very struck by Griffin's presentation, and it brings up, I think, where the duals live, rural or urban, the supply of primary care providers, and what that looks like and how -- I guess how vital not just the attribution, which suggests it's more of a financial arrangement or even, but really the attribution for managing the care, how vital it is to have primary care. I am assuming it is, but on all these models I would think that it's critical.

I have expressed many times to the Commission my concern over the workforce issues, but particularly, in this case, primary care, and as Griffin pointed out, the independence of the primary care, and how different that may make it.

CHAIR BELLA: Brian, your mic is on. Are you wanting to talk?

COMMISSIONER BURWELL: Yeah, I just -- I mean, I don't want to be critical, but they are not involved in managing LTSS services at all. So, I mean, they are not really a full continuum, integrated product themselves. I agree, I mean, it's a great product for the primary care part, but their members who are receiving Medicaid-funded

LTSS services are receiving them somewhere else, without any coordination from their practice.

COMMISSIONER RETCHIN: Yeah. No, I don't doubt that, Brian, though, I mean, listening to Griffin's presentation, from a provider standpoint -- and, listen, I think the duals, it's a very heterogeneous group. Maybe that's what you're bringing up. And maybe primary care is not a critical ingredient.

CHAIR BELLA: In some cases they are coordinating. That's his point about getting the data. So like in Illinois, for example, they got Illinois demo participants Oak Street cares for, and they take risk from that demo plan that has both in there. And so as long as they have those data, I got the sense that they are coordinating. They are just not at that financial risk in the same way, and they don't have LTSS in their network.

COMMISSIONER RETCHIN: And not to expand the argument or the concern, but I will anyway express that I'm concerned a bit by restrictive scope of practice issues, and now you're getting on to the state level, but where they're -- I think for this population, much less the entire population for Medicaid, I think we need all hands

on deck, and I just think we ought to be looking at that as well. I don't know how Martha feels about it.

CHAIR BELLA: Kit.

COMMISSIONER GORTON: So I'm not sure where to take this to be helpful to the staff, so I'm just going to say it maybe it just sits out there and periodically I'll trot it out and ride it as a hobby horse. I'm not necessarily asking you guys to go and do something.

But a couple of noted in the last session that there's this issue in what I've called the walled garden in terms of network design. So you pick who's in your -- in managed care land we call this referral service, right, and when we were building these ACO models, in Massachusetts, for the 1115 waiver, it was, okay, so we're going to align this group of PCPs up with this group of hospitals, with this group of specialists.

And the fact that you were an older person living in Chinatown in Boston, getting your primary care services from the FQHC there, and used to going out to Longwood and getting your specialty services out there, we had no qualms whatsoever in terms of disrupting that, and saying, "Nope. You can keep your PCP or you can keep the specialists who

are being aligned with your PCP, within this ACO construct." But the ACO model is going to be -- it's a closed model. It's a closed-panel model, and it is a very limited network.

And so at the state level you're offering people choice because they can pick amongst the networks. But, in fact, it's no longer Norwegian Cruise Lines that you can just walk through the buffet table and pick where you want to do and what you want to do with it. It's if you choose this is your PCP, then, oh, by the way, this is where you're going to go to the hospital, which you may or may not like, and this is where you're going to get your specialty care, which may or may not be the perfect fit for you.

And so I think we need to think about that. And I get very concerned, then, when we start to talk about LTSS, because while I think the plans all have a lot of experience in terms of building high-quality, limited networks, I don't think the plans have anywhere near that level of expertise in terms of building a high-quality LTSS network, and I think people's needs will be very, very different.

We saw, in the Financial Alignment Initiative, in Boston, that that population of people, the under-65 duals, fragmented into several big clumps. There were the people with behavioral health and substance use issues, there were the people with physical disabilities, and there were the people with intellectual and cognitive disabilities. Those people's needs for primary care is different, those people's needs for specialty care is different, and those people's needs for LTSS care is different, right down to the culture of the model of if you're a young person with a disability then the philosophy of centers for independent living and the right to risk and all that other stuff, you ought to be able to choose that. And if you're a senior then it's safe aging in place, right? That's the philosophy for seniors.

And so I just think we need -- I want to sort of throw it out there for us to chew on, and I'll jump on this hobby horse periodically, that, yes, I agree that integrating care make sense, but integrating care means pre-engineering choices. It means setting up a set of interfaces and referral circles and data-sharing and other things. You can do it effectively with multiples-to-

multiples. It all gets weaned down to few-to-few kinds of relationships.

And what that means is that if you love your PCP, and you love your cardiologist, and you hate to death the endocrinologist who has been assigned to you to take care of your diabetes in this closed network, then you are out of luck.

And so that is a cost to the beneficiary, it's a cost to the families, and I think we need to keep that front of mind as we think about not that we shouldn't drive people in the direction of integration, but do we know what we're doing? And particularly when we start to think about folding in long-term services and supports, you know, I think that adds a whole level of complexity which makes me anxious.

CHAIR BELLA: Okay. I was accused of skipping over someone. Darin, do you have a comment? Not that he is the one that accused me or anything.

COMMISSIONER GORDON: I am exactly the one that accused her.

So on that point, though, Kit, you know, it was some of the questions that were going on in your earlier

comments, you know, that we don't have the evidence base yet on the true value of integration. But at the same time, you know, I don't think we can dismiss some of the impacts on outcomes of unnecessary inpatient hospitalization, unnecessary ED visits. Because I don't know if anybody has done a study on it, or if one is even needed. I don't know of anybody that says, yes, I enjoy going to an unnecessary inpatient hospitalization, or unnecessarily being rushed to the emergency room.

So, you know, in that same vein, I think what it boils down to is -- and it was discussed by the panel -- the need for better communication about the value of some of these integrative products. I think there is a lot more that can be done there, and in a way that, you know, I think is helpful for a consumer. I do also think that, you know, the comment, you talked about the walled garden, multiple times too, is that Chuck and I, on our ride over, he was pointing out that, you know, there is a fairly large percentage of these D-SNPs that are more PPO models that are out there than I had even anticipated.

So it isn't necessarily -- I think we've just got to -- as everything in Medicaid, it is more complicated.

We can't say they're all HMOs or that they're all restrictive provider networks. I think, overall, this was an excellent panel, and I think getting down to, you know, getting to a recommendation I think is something that we need to continue to explore, because there are so many different directions we could go with this.

CHAIR BELLA: Brian?

COMMISSIONER BURWELL: So I want to talk about recommendations too. I feel like what we've done thus far in this area, at least this year, I mean, there are so many different paths we could go down in regard to recommendations. And if we're going to do recommendations, you know, for the June report, I think we have to start winnowing down what we think are the most priority items that we want to address, whether it's enrollment choice, all kinds of things, D-SNPs alignment.

So I'd like to have, you know, just recognize that. Oh, Anne's going to say something.

EXECUTIVE DIRECTOR SCHWARTZ: No, I was going to say, that's sort of that's where we're going, we're going to try to go for the December meeting. But we're going to try to go at the topic concept areas, not at the specific

recommendation. We're going to start sort of homing in towards that and get feedback from you all about different things. What do you think is priority? Where do you think we can have the most impact? How specific is the tolerance in the room for some of those? So that is the next step, so thank you for raising it.

COMMISSIONER BURWELL: Two more things I want to say. I'm impressed when I hear Melanie talk about how, you know, we started this with the ACA and the creation of the office, and the recent history is the history of incrementalism, of doing minor things to get more integrated models. And so I think that's one decision. Do we, you know, think incrementalism? Next year is a political -- you know, who knows what's going to happen. But we also heard the recommendation we need a new title -- I mean, way up there -- or we should only have one model, you know. Those are -- I don't know whether we should entertain that.

The second thing is, we have to always acknowledge that there are only 23 states that have Medicaid MLTSS. Most states are still fee-for-service LTSS. So what do we say about those 27 states, in terms of

developing more integrated programs? You know, we have a couple of models out there that we could do, but I don't think we should ignore 27 states either.

CHAIR BELLA: Okay. I have several comments. Take them or leave them. One is, I just want to kind of -- one is just sort of information-setting. You heard a lot about passive enrollment and opt-in and opt-out and disenrollment. I just want everyone to understand, like there was wide differences in the states. In Ohio, for example, very strong participation. In California, lots of opt-outs. And when you did a deep dive into what was causing those opt-outs it was very much driven, in that case, by a group of folks that were getting care by paid family caregivers who were worried that participation in this program would mean they wouldn't be able to continue in that role.

So there's a lot of stuff that goes into opt-out and disenrollment, and I want people to understand that like it's not uniform across the states and there are a lot of things we could learn from that, but I don't think that necessarily came across. So that's just an information point.

The second point is, we talked at the last meeting, and I would encourage us to keep thinking about it, about what is integration. And I'm not suggesting we go on this academic exercise about what is integration. But as we think about integration, it particularly has a difference for people that have LTSS needs and don't. And so I do think we should think about like what is integration, not seek to solve what it is but keep that in mind.

The second point is we do need to talk more about choice. A lot was said about choice today. I think as we look toward making recommendations, one thing is kind of in this world where there are so many choices, like is that actually serving anyone well? And so I would encourage us to think about choice on both sides, from a consumer protection lens and also from a consumer confusion, and sort of like people are going after this population for may bad reasons lens.

In terms of making recommendations, I have sort of a few areas that we could think about. One is I would like us to consider, within the existing world there are a couple of things we could think about. The Financial

Alignment Demonstrations are still demonstrations. There could be a recommendation that they are made permanent and that they are opened up to other states. So CMS has opened them up to other states, through a state Medicaid Director letter. It could be that we decide that should be a permanent program option and that is something that we could recommend.

We should also talk about what we want to recommend, if anything, about the relationship of D-SNPs and Medicaid contracts. So furthering, pushing the FIDE-SNP concept of taking on, or looking at some of the things that MedPAC has raised in its report.

If we want to go bigger not stay within the existing, we could recommend a new title. That might be a little big for us this year. We could bring that back next year. We could also look at making recommendations for something to move states along so that there is some sort of push to move states, whether it starts with LTSS and moves then to an integrated product. But we are not -- we haven't opined on that. If we think this is important and we think it's something we want states to do, we could make some sort of recommendation.

But I would say my last point is, any recommendation we're going to make, we have to recognize that states need capacity and bandwidth to do these things. So it would be ridiculous for us to recommend that all states had to do LTSS or all states had to have an integrated program, if we didn't give them any resources to do something with that.

Just the other day I had talked to another state and I said, "I don't understand. I know you want to do a duals demo. Why aren't you taking CMS up on their offer?" And she said, "I just need some money." And I said, "Well, how much money do you need?"

Well, when the Financial Alignment Demonstrations came out, each state got $1 million. A million dollars in the grand scheme of things is not much, but for those states, they hired dedicated staff, and that’s who’s run those programs. And so these new states, there is no resources to help them. And so anything we do, I never want us to lose sight of the need to kind of think about that piece as well.

So I'm off the soapbox and turning it to Chuck.

COMMISSIONER MILLIGAN: I think building a little

bit more of kind of evidence and background would be helpful. I want to start from the perspective that I think integration is a good thing and I think there's a lot of agreement around that. So I would frame up kind of what are the barriers to integration, or where is it going, and I think Melanie has tagged a few, having to do with state infrastructure and some other pieces.

I want to flag, I do think it would be helpful to try to have some understanding of opt-out and the enrollment issues. I think that would be a helpful thing to kind of lay the foundation to understand integration barriers better.

I think it would be good to have better understanding about how states can share in savings they might produce on the Medicare side. That's certainly kind of a component of MMP. But I think having an understanding about the alignment and the financing incentives as a potential barrier is worth learning more about.

I think we should have an agenda in terms of how to evaluate the effect of the final integration rule that was promulgated by CMS April 5th. And there is going to be more data sharing. There is going to be more alignment

with accessing Medicaid benefits. I think we need to figure out what our framework is going to be and what data we are going to need to measure that, because that's intended to solve some of this stuff.

And the only other comment I guess I want to make is, there has been a lot of talk about Medicaid LTSS as a critical part of integration. I believe that. But I don't want to lose sight of integration back to the Medicaid especially behavioral health world. A lot of dual eligibles, especially under 65s, do have severe or persistent mental illness, they have addiction, there's a lot of complexity there. And linking back to kind of the Medicaid BH benefits as a component of keeping them out of the hospitals, keeping them stable, dealing with med adherence, all of that, I don't want to lose sight of the BH piece of this picture.

So I guess that's what I wanted to contribute.

CHAIR BELLA: Darin.

COMMISSIONER GORDON: Just adding one thing. When you talked about enrollment and you talked about past enrollment, I think you have to also include default enrollment. One of the points Michael had made was, you

know, in the context of default enrollment you are taking folks as they transition into Medicare, but then for all the people that are on the program already, you know, they don't have that similar pathway available to them.

So I think as you look at enrollment, not just past enrollment, looking at default enrollment as well and some of the barriers or opportunities there as well.

CHAIR BELLA: Kit?

COMMISSIONER GORTON: So I just want to respond to Darin. I agree what you said before. I think you are absolutely right.

It seems to me -- and maybe this is wrong -- that we do have a consensus that, at the very least, everybody should have a choice of an integrated model, and I wonder if there's a place for the Commission to make that as a recommendation, and to focus on what are the barriers that make it difficult for states, whether it's in the MLTSS space or whether it's in the medical space, to offer? Right?

Because I think it's one thing to say we need to mandate people. That does feel paternalistic to me to say you've got to be in an integrated model because it's good

for you, and just, you know, shut up, hold your nose, and swallow your medicine. But I do think that there are people who might want and crave an integrated model, and I think that there are very legitimate reasons why that option hasn't been offered to them -- you know, they're in a frontier county, you know.

And I think perhaps it's useful for the Commission to draw the conclusion that, at the very least, everybody should have an option to choose an integrated model, if you want to choose an integrated model, and what are the things that need to happen in order to let that happen? I wonder if that isn't an intermediate step that the Commission could work on in the next 12 to 18 months.

CHAIR BELLA: Fred.

COMMISSIONER CERISE: One of the things I was struck with on the panel, and whoever put that together, thank you. That was a great mix. Thanks, guys. But the provider role, Griffin's role, was really impressive. And we talk a lot about the payers and what we can do to integrate, but it goes through those guys.

And I would maintain some emphasis or attention to, you know, the practice transformation issue, or what

lessons you can learn from those models, and how you could push that, because, you know, I may be a little surprised at the magnitude of the impact but I'm not surprised at the concept that if you invest more time and really organize, things that you don't typically get paid to do in practice, if you invest in that stuff it's going to pay off. So I would maintain some attention on that piece.

CHAIR BELLA: All right. The last thing that none of us have said that I want to just be on record saying is we should continue to talk about lookalikes. I mean, we heard that from both panelists, we heard that last month from Tim. The most recent letter we commented on, to CMS, we included that as a flag, that it's undermining Medicaid integration. So I just wanted to make sure we keep that on our list.

All right. Any last comments before we break for lunch?

COMMISSIONER BROOKS: Just a quickie in terms of also, you know, looking at it from the beneficiary's perspective. I mean, this is so complicated, and I think about just regular Medicaid managed care and choosing the right plan and understanding, you know, how to get enrolled

and what your rights and responsibilities are. I mean, this just seems like it's 100 times more complicated. And beneficiaries need independent support in assessing what their needs are and making those choices, and that requires some real resources as well.

CHAIR BELLA: All right. Do we have any comments from the public?

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: I'm sensing some dual fatigue, which I can't understand. This is the best subject in the world. Did you have a last comment, Bill, and then we need to break.

COMMISSIONER SCANLON: I was just going to follow up on the lookalikes. I mean, I think that very often when we've discovered something that we don't like, when we look into it, if we follow the money, we know why it's there. And if you change how the money flows, it will go away. And it has happened so many times in policy; the response is almost immediate. So I think that's where we need to be looking, is why do these people want to be lookalikes?

CHAIR BELLA: All right. Thank you all for a

very rich morning of discussion. We will adjourn and we will come back at 1:00 with a public meeting.

* [Whereupon, at 12:01 p.m., the meeting was recessed, to reconvene at 1:00 p.m., this same day.]

AFTERNOON SESSION

[1:10 p.m.]

CHAIR BELLA: All right. Welcome. We are excited to hear about state readiness and the mandatory core measures. So, Joanne and John, we'll turn it over to you. Thank you.

STATE READINESS TO REPORT MANDATORY CORE SET MEASURES

* DR. WEDELES: Good afternoon, Commissioners. Thank you.

Today Joanne and I will be briefing you on findings from our study of state readiness to report the CMS core set of health care quality measures.

Before we begin, we thought it would be helpful to provide context as to the importance of this issue. Reporting of the core set will be mandatory beginning in Fiscal Year 2024. While the date may seem far off in the future, we know that this will require a substantial amount of planning, time, and resources on behalf of state Medicaid and CHIP programs. This is an opportunity to examine what states will need in order to facilitate mandatory core set reporting and how the mandate could be

implemented.

The purpose of our presentation today is to share what we've learned and to solicit feedback on whether this work raises any policy questions for further consideration by MACPAC.

During the presentation, we will review background, study approach, key findings, factors that may improve state readiness for mandatory core set reporting, and potential next steps for consideration.

As background, the Children's Health Insurance Program Reauthorization Act of 2009, or CHIPRA, required CMS to develop a core set of children's health care quality measures in Medicaid and CHIP.

Similarly, the Affordable Care Act required the development of a core set of adult health care quality measures in Medicaid. The child and adult core set measures were established to provide CMS and the states with a mechanism to collect and report a standardized set of measures to improve the quality of care for children and adults covered by Medicaid. Reporting for both the child and adult core sets is currently voluntary.

However, beginning in Fiscal Year 2024, reporting

on the full child core set and on the behavioral health measures within the adult core set will be mandatory. The mandates were established through the Bipartisan Budget Act of 2018 for the child core set and through the SUPPORT Act of 2018 for the behavioral health measures in the adult core set.

Since their initial introduction, the core sets have changed slightly from year to year. By statute, the Secretary of HHS is required to review the measures on an annual basis and suggest updates, as needed.

The Fiscal Year 2019 core set measures, which were released in November of 2018, consist of 26 measures in the child core set and 12 behavioral health measures in the adult core set.

State reporting of the core set measures has increased over the last several years, but it varies by state and between the adult and child core sets.

There are a number of documented challenge states face in core set reporting. These include limited access to data, particularly for certain populations, as well as constrained staff resources.

In addition, states have noted challenges when

core set measures are similar to but not identical to certain HEDIS measures in the way they are calculated. This is an important issue because although many states rely on plans to report core measures, they are more likely to require their health plans to report HEDIS measures. As a result, differences between HEDIS and core set measures create an additional burden for states.

We will be discussing this issue in greater detail when we present the findings from our study.

In anticipation of the reporting mandate, we contracted with Mathematica to examine state planning efforts, perceived challenges, and readiness for mandatory reporting. We interviewed staff from health plans, including comprehensive risk-based managed care organizations and behavioral health organizations, CMS staff and contractors involved in core set reporting, and Medicaid and CHIP programs in seven states.

I will now turn it over to Joanne who will discuss the study's key findings and introduce potential next steps for the Commission.

* MS. JEE: Thank you.

All right. So over the course of our

conversations on this project, we definitely heard from states and plans that the mandatory reporting is on their radars, even though it is still some number of years away.

They also said that at this point, they really haven't heard definitively from CMS yet on what the expectations will be for the reporting and what that reporting actually will entail.

States really need this guidance from CMS, so that they can begin to anticipate what kind of planning they will need to do. Without any specific information, states told us that they don't really know what additional data they will need to obtain, what systems or contract changes they will need to make, and the level of additional resources they might need to put forth to the effort.

We do know that CMS is working on this. They were not able to share, at this point in time, very many details as to their plan or the timeline for releasing guidance.

So states do have experience reporting on the core set because it has been voluntary for a number of years. So they were able to draw on that experience to describe many data challenges that will be before them as

they look to 2024.

One of these has to do with medical records and EHR data and accessing those data. Those data are used for several of the core set measures, and when those data are used, it can improve the accuracy of measurement. However, medical record abstraction is very resource-intensive, and the ability to exchange data between providers, plans, and states can really be stymied if the electronic health records, or the EHRs, lack interoperability.

States had some mixed views as to the feasibility of reporting on measures that rely on EHR data for 2024. One state told us that they just didn't think that they could meet that timeline because of the interoperability issues, whereas another state told us that they thought that they probably could do it but would need something like at least two years to put all the processes in place to make that happen.

Certain other measures require data from other state entities. Those include things like immunization registry data or state vital records data, and once those data are obtained, those data have to be linked with the Medicaid administrative data. And creating those linkages

sometimes can be difficult, particularly if the systems don't have a real way to make those linkages.

One state told us that they use names and dates of birth to create those linkages, but that any error in those fields could lead to problems and impede those linkages from happening. Of course, in order to obtain the data, the Medicaid agencies would need to enter into some sort of data use agreement with those other state agencies.

Some states told us they didn't really have very much experience doing that. Another state told us that it probably would take at least six months to do it, and CMS also noted that it can be challenging for states to do.

John mentioned getting data for certain populations can be a little bit challenging as well, so that's an issue that states have experienced historically, and that will probably be likely to continue as they look to 2024.

Some specific populations for which that is true include tribal populations, data of individuals who are behavioral health care service users, as well as individuals who are dually eligible for Medicare and Medicaid.

Data quality and timeliness was also raised as an issue. For example, sometimes administrative data can be incomplete. For example, if a state pays for maternity services using a global fee, there aren't individual claims for prenatal and postnatal visits, and those are data elements that would be required for certain of the core set measures.

The CAHPS survey, which is a survey of user experience, provides an example where timeliness of data can sometimes be a problem. Some states told us that they don't field the CAHPS survey every year, and so, obviously, in the years in which the survey isn't fielded, there wouldn't be data available. There also can be lags in certain other data, such as vital records data.

So the last thing here on this slide is adherence to technical specifications. John mentioned that there can be differences between core set measures and HEDIS measures. It is easier for states to report on HEDIS measures because they get a lot of support from their health plans in doing that, and so they would use the HEDIS specs.

When the core set technical specifications veer

off of the HEDIS core set or if the core set measure is a totally different measure, states have a harder time just calculating, getting the data and calculating those measures.

States also anticipated that their administrative capacity would be stretched in meeting the mandate for 2024. This is probably not a big surprise.

States and plans said that they would need to hire and train staff, both for data collection as well as various measure production functions and different supervisory roles. This is especially true where there will be fee-for-service reporting and reporting on those nine HEDIS measures that we talked about.

In addition to the extent that medical records abstraction will be required, both plans and states told us that they would probably need to hire clinical staff to take on those tasks.

In addition to core set reporting, states are involved in numerous other state-specific quality initiatives, and some of those initiatives can involve reporting on measures other than the core set. Obviously, states have limited budgets and limited staffing. We

talked a little bit about some data constraints. So states are really working to balance sort of, within that context, their work on the core set measure reporting as well as the other initiatives. So they're having to prioritize, so far in this voluntary environment, which of the core sets that they're reporting.

CMS is very much aware of these capacity issues, and as they are involved in their sort of planning phase, they are taking all of these factors into consideration.

They told us that they are definitely seeking ways to reduce burden on states to the extent that they can. For example, they're considering what their options might be to use data that they get from states to report on some of the measures. Those would be measures for which administrative data are used, the idea being that if CMS can do that, then the states could spend their energies and their resources on those other measures that use something other than administrative data.

CMS also said that they thought that there might be ways that states can use the External Quality Review Organizations, or the EQROs, to help support their efforts for core set reporting.

So here are a couple of other challenges that we heard from states. They wondered how future changes to the core set will be handled once reporting becomes mandatory. As John mentioned, the core set is reviewed annually, and there are changes made to the core set, including the addition of measures. And when that happens, states need time to ramp up to be able to report on those measures.

The second bullet here has to do with sort of the states had some ideas on how to improve the system into which they report the core measures, which is called MACPro. They noted that it was a little burdensome. There was a lot of manual data entry. It took a long time, and they worried about the introduction of error with that manual data entry.

Okay. So we also tried to get at what kinds of things would be helpful to states to improve their readiness for 2024. We talked a little bit about the guidance, but again, just to sort of drive home that point, the states told us that without guidance from CMS, they really don't know what they're supposed to be planning for. So they were hoping that that guidance would come soon.

There are several questions that are left

unanswered, including what measures will be included in the core set for 2024, how will the mandate be rolled out, are all the measures going to be mandatory all at once, is there may be an option for some sort of phase-in, and whether deviations from technical specifications would be acceptable in the future.

States also said -- and they really emphasized this point -- that they needed an implementation timetable that would give them the amount of time that they needed to implement or take many, many steps to implement the reporting mandate.

Some of those steps are listed on this slide here, and just to highlight, we did hear from at least a couple of states from the point in time at which the core set that will be required to be reported is identified, that they would need at least two years to sort of ramp up to that and to be able to report on those measures.

Of course, that is sort of all in the context of what we know currently about the current core set, and who knows what actually will happen?

Okay. With respect to technical assistance, states were all very positive about the technical

assistance that they had been receiving from CMS thus far for the voluntary reporting. Technical assistance has included such things as webinars, TA briefs, and one-on-one technical assistance. States really thought it was useful. They identified a number of other places where they could use some additional TA from CMS, and those are listed here on this slide.

Lastly, states said that they really needed some resources to prepare for their reporting mandates. This included hiring new staff, training new and existing staff, and, of course, financial resources.

All right. So, with all that information in mind, Commissioners, we seek your input on what you think next steps are here.

To kick off your conversation, we jotted a few things down on this slide. Staff could take the information from this work along with the key points from your discussion today and put that into a chapter for the March report.

You may also want to consider whether there is a need for any sort of recommendation here. For example, previously, you have made recommendations related to the

issuance of guidance, where you've recommended that the Secretary of HHS issue guidance to clarify a policy or answer questions about ways you could cover certain services. Therapeutic foster care comes to mind.

You could also take a more wait-and-see approach in which case staff would continue to monitor state reporting of the core set measures, and we would await guidance from CMS and see what next steps they take.

So, with that, we'll turn it back to you.

CHAIR BELLA: Great. Thank you both.

Martha?

COMMISSIONER CARTER: Thanks for that.

I want to just highlight. In the primary care world, reporting quality measures is easiest if there is an electronic record and the clinician checks the box. But that assumes that the box is there, and it assumes that the measure is configured exactly the way it needs to be reported.

I found that EHR vendors are generally pretty willing to build that capacity into their systems. They've done it with meaningful use and MIPS and patients at a medical home, but they are going to be reluctant to build

that capacity into their EHR until the guidelines are finalized and required because they don't want to have to do it twice. And it costs them.

So I would say that that's a really important step in the state being able to get the data, especially the clinical quality data, from clinicians is to make it finalized, so that everybody is willing to make the investments in the systems that are needed for the reporting and make it required, because if it's not required, it's --

CHAIR BELLA: Peter?

COMMISSIONER SZILAGYI: Yeah. Thank you very much.

First of all, just kind of in disclosure, I participated in the creation of the child core set, and I have to say that there was a tremendous amount of thought put into it about sort of weighing the benefit of individual items with the feasibility, the practicality, reliability of these measures, how similar they are to HEDIS or other measures. There was really a lot of thought about it.

I do think that it is worth a chapter. I would

recommend that there's some context placed early on in the chapter about why this was even done, because right now it almost looks like this was sort of a regulation foisted. But there was a strong rationale that if you don't have quality measures, you don't really know if you're delivering quality, and without quality measures -- so if you have quality measures, it doesn't necessarily guarantee quality, but it's something to shoot for. It allows states to judge themselves over time.

Some of these measures were really designed so that certain states may have different baseline levels, but they could compare themselves over time or they could compare to other states, et cetera, same as within a managed care world. And it's moving states more toward population health. So I would put some sort of context there.

And I do agree with the need, and this was in the -- those who designed the core sets, there was a great understanding that there would be a need for resources and technical assistance and guidance, and some of the measures would be easier than others, but that the reasons for some of the measures being based on electronic health records

rather than just administrative data was that you just can't get some of this from administrative data.

CHAIR BELLA: Kit, then Tricia, then Toby.

COMMISSIONER GORTON: So I absolutely agree with what Peter just said, and I don't object to us working on a chapter. But if we're going to work on a chapter, I do think an important material and meaty component of that chapter has to be focused on the pragmatic reality of operationalizing measures, a set of measures. Doing these exercises -- and I've been involved in these exercises since the 1990s -- is hard, it's complicated, it's expensive. It's not -- you know, people think, oh, you just go on a computer and you push -- no. It's weeks and weeks of work. To do one of these exercises for the children piece of it, you have to pull 10,000 records. That means you hire a small army of nurses, and you fit them with portable scanners -- unless you're lucky enough to be working with a lot of offices that can give you the information. But, still, where we are in this country is better than half of your records will be gotten by nurses getting in cars, driving to providers' offices, and scanning -- looking for records and scanning records. The

provider staff is then standing there maintaining privacy and everything else.

Keep in mind that they're not going to do this just once. They're going to do this for every health plan that they participate in. So it goes on and on and on. I've got to believe that Fred's place has actually people whose full-time job is supporting this kind of stuff, right? It's very, very expensive. A CAHPS survey, you field the CAHPS survey, it's a million bucks to field the CAHPS survey. Oh, you want to do adult and pediatric CAHPS? That's two million bucks. Oh, you want to do this for a population of 5,000 people and your new implementation in the state of Rhode Island? Why would you want to do that? Fine, you know, two million bucks on the back of paying for, you know, capitation for a very, very small population, and then you won't get enough numbers, and they won't be statistically valid, and blah, blah, blah.

So I do think if we're going to do this, we need to talk about the proliferation -- and Peter's right, the committees that have worked on this have struggled with this balance, because everybody has their pet five metrics

that they want in the set. And yet they don't translate across. If you go to a hospital system and you say, okay, here are the Medicaid measures and here's the Medicare Advantage measures and here's these measures and here's those measures, you've just given them a thousand measures. And how do they focus, right?

So the other thing I do think we need to talk about, at least at a qualitative level, is what is the point of measuring stuff. It is true that if you don't measure something, then it doesn't happen. So, absolutely, you need to measure stuff. But there's stuff out there that we've been measuring for years and years and years and years and years, and it's still the same lousy numbers years and years and years and years and years. So if there isn't an action arm that's going to take the information, assuming that it's valid information, and do something with it, then spending all of this time and energy sending nurses out to doctors' offices -- which is not time spent taking care of people. It's time driving down country roads to doctors' offices.

I just think if we're going to address this in a formalized, reasonable way, then we need to have the

discipline to say, okay, and here's the cost, here's the opportunity cost, here's the number of nurses that a health plan will employ to do this, not once but five or six times. We'll do it for every product. Here's what it takes. Here's the cost of doing these things. And what value do we buy?

So for me, the question is we already have the most expensive health care delivery system in the world, and we get crappy quality for it. Do we really believe that investing tens of millions of dollars in doing this kind of exercise on top of the exercises which are already being done is a path towards getting to a better place? I am skeptical of that, but I do think if we want to deal with this in sort of a neutral and balanced way, we need to say, okay, here's what it takes to do this kind of work.

CHAIR BELLA: Peter, given your involvement, we'll come back to you at the end and see if you have any other words of wisdom.

Anne is reminding me, Kit, the answer to your question is Congress said yes, this is important.

COMMISSIONER GORTON: Right, but we're here to advise Congress, right? So if Congress said yes --

CHAIR BELLA: I didn't mean to open up a -- just sort of injecting some levity here. Tricia, then Toby.

COMMISSIONER BROOKS: And full disclosure, I currently sit on the annual review work group for the child core set and have been following this since its implementation in 2009. So we've been at this for ten years, and there are certain states dragging their feet. But 80 percent of the states are reporting 11 measures, and 19 states are reporting at least 21 of 26. You've got several states at 24. And each year there is, you know, another -- you know, there's a few tweaks along the way, one or two or three, that I think the work group that reviews this, you know, is very cognizant of, you know, why you would switch things up. But I think it illustrates that there are states that are doing a pretty darn good job of measuring the quality of care.

I think your study certainly captured -- and thank you for this -- captured most of the things that I've heard as I've looked at this particular topic. So there are a couple of things that I would reflect on that, you know, it could play into next steps.

One is this tension between HEDIS and plan -- or

state requirements that plans be accredited. I would not like to see us go in the direction of defaulting or recommending that we only do HEDIS measures, and the reason for that is that, you know, if you look over the history, you will know that child quality measures have never been a strong suit in HEDIS. And there are missing areas that certainly need to be measured, and I will just point to developmental screenings as being a really critical measure that is not a HEDIS measure.

And I know it's challenging for states, but in particular when it comes to children and early childhood health outcomes, I mean, that's really where the trajectory starts in life for people who become adults with multiple chronic conditions.

So I just think it's really important that we continue to forge ahead. The fact that states are waiting on guidance, I get a little, you know, confused about what that guidance might be because there are all kinds of technical resources out there about what the measures are. There are resources that CMS and Mathematica offer to the states. Now Congress has said we're going to mandate reporting, we're giving you a five- or six-year ramp-up

here. So what are we waiting for other than perhaps something like if -- when a new measure is introduced, you have a three-year, you know, phase-in or something. I mean, I think you could get into details like that, but certainly I'm not certain why the states feel like they need a lot of detailed guidance. It's not like the core set hasn't existed.

CHAIR BELLA: Toby.

COMMISSIONER DOUGLAS: Kit said most of what I wanted to say more passionately and profusely. But I do step back from a state perspective and what are we trying to solve. Is this the right approach? I know Congress, this is what they wanted, but if the reason we're not getting good -- states are still standing on the sideline, is it because they believe there are other approaches or they have already effectuated other approaches through their managed care contracts? Are there ways to get to the same end goal of transparency and outcomes? And so I do think with all the administrative costs and inefficiencies and the fact that we're not getting the progress, are there other approaches that could get to the same end goal?

CHAIR BELLA: Darin.

COMMISSIONER GORDON: I agree with many of the things that have been said to this point, but one thing I was surprised not to see under the other challenges was -- and this is from past experience of doing similar things. There's a provider education requirement when you do these types of things, and it gets into the issue -- and we ran into this even for our administrative claims information where you want like a -- you know, you want that information so you can populate a quality measure. However, if a provider submits a claim without it, you're basically putting the plan in the position to reject the claim, send it back until it gets corrected. And it just creates a lot of abrasions.

So I'm just surprised, you know, that that wasn't a factor to one of the challenges to this because, you know, my own experience, that does take some time and, you know, you think about it, it's not all of the providers you have in Medicaid obviously doing this, but you have thousands and thousands of providers with varying degrees of sophistication within their practices. And so that just -- I just wanted to make sure we got that out there as well because that is a part of any initiative in this area.

MS. JEE: So that did come up during the interviews just in terms of sort of the effect of what providers do in terms of the data. So that did get raised.

CHAIR BELLA: Peter, do you have any comments based on what's been said or any insight?

COMMISSIONER SZILAGYI: I actually agree with what everybody said. Just a couple other comments. I think this is a great example of where we're trying to balance something where we don't have the perfect evidence and we don't have the perfect technology, because if the technology was perfect, there wouldn't be nurses driving around to practices. We would be getting it electronically. And so, you know, the question that we're often faced with in medicine is do we wait for the perfect evidence, do we wait for the perfect technology, or do we sort of move ahead right now. And I think this was, you know, a classic example of that.

The second point I was going to make is that the makers -- or the original thought leaders in terms of these quality measures really wanted to get more in the world of improvement over time rather than comparing one state versus another or one program versus another and to try to

get out of where we are too frequently in this country where we're looking at bad apples versus good apples as opposed to looking at how do we improve our system, our own systems continuously over time. And that was really one of the -- you know, so, therefore, reliability was one of the key components here.

Maybe the third point I was going to make is Tricia had brought up the issue of developmental so let me just contrast two measures: immunizations and developmental screenings. One is easier to get and the second is harder to get. But in the immunization world, we've had a clear metric. We've had state registries. We've been reporting immunizations at the state level every year for the past 20 years and reporting improvement over time. Developmental screening, we haven't had any of that.

So where are we the outcomes? We have actually very high immunization rates in this country, and we have very poor developmental screening rates. So I'm just, you know, making an example, sort of a contrast in which you do need measures and you do need resources, because there's been a lot of resources pumped into the nation for trying to raise immunization rates. So as Kit says, you just

can't do the metrics without the resources, but just if you look at that contrast, you can see something where we're performing very well and where we're not performing very well. And so I think we might be able to use a chapter as an illustration of that.

CHAIR BELLA: Yeah, one last comment and then we're going to open up to the public.

COMMISSIONER BROOKS: So just a quickie. One of the things that I've heard some folks bounce around is the idea of a performance bonus system for states, similar to what we did around enrollment back with CHIP reauthorization in 2009 that would reward the states not only for reporting but mostly for making progress against their own baseline as opposed to comparative to other states. But as I understand it, Congress probably wouldn't appreciate that recommendation from us because they don't actually like performance bonus programs. But it is a concept that could have some merit.

CHAIR BELLA: Thank you.

Would anyone in the public like to comment on this issue?

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: All right. Well, I think what you should be hearing or what I'm hearing is definite support for a chapter in the report, and I think the chapter, it's a great idea to give context, as Peter suggested. I think it's also important to have the pragmatic lens that Kit and Toby and others have raised as we think about sort of the bang for the buck and making sure that we're getting what we intend to be getting from this. But it feels to me like we're not at a recommendation point, but mentioning the guidance is a barrier, and for you all to continue to keep an eye on it and continue to let us know as the clock ticks down I think it feels to me like where the Commission is.

Any Commissioners have any last comments? Anybody feel differently than that kind of where I feel like we've landed?

[No response.]

CHAIR BELLA: Okay. Thank you both very much. John, I think you're staying, right?

All right. We're now going to turn our attention to the new buprenorphine prescribing authority for advanced practitioners.

John, whenever you're ready. Thank you.

FINDINGS ON EFFECTS OF NEW BUPRENORPHINE PRESCRIBING AUTHORITY FOR NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

* DR. WEDELES: Good afternoon again. The purpose of this presentation is to provide a summary of findings from our analysis of buprenorphine prescribing patterns among advanced practitioners in Medicaid following the 2016 legislative expansion of prescribing authority to nurse practitioners and physician assistants, or as we will be referring to them throughout the presentation, advanced practitioners.

During the presentation, we will review background on the issue, the study approach, key findings, and then close with a discussion of policy implications and next steps.

As we have previously demonstrated, Medicaid beneficiaries have disproportionately higher rates of opioid use disorder, or OUD, are prescribed opioids at higher rates, and have an increased risk of overdose compared to those with other types of insurance. Congress has taken a number of steps to address the opioid epidemic,

including addressing concerns about limited treatment capacity among providers.

The Drug Addiction Treatment Act of 2000 permitted qualified physicians to obtain waivers to prescribe buprenorphine for OUD. These waivers are typically referred to as DATA 2000 waivers. The Comprehensive Addiction and Recovery Act of 2016, or CARA, expanded prescribing authority for buprenorphine to nurse practitioners, or NPs, and physician assistants, or PAs. As noted, the first DATA 2000 waivers were approved in February of 2017, which helped inform our study design.

MACPAC contracted with IMPAQ International to examine the effect of CARA on access to OUD treatment for Medicaid beneficiaries. IMPAQ analyzed data from the Symphony Health Integrated Dataverse, which included anonymized patient claims data from retail pharmacies, from July 2017 to June 2018. We chose this time period because, as we just noted, the first waivers for NPs and PAs were approved in February of 2017. We looked at prescribing trends, looking at differences by geographic location, state scope of practice laws, and provider specialty.

In general, we found that the number of

buprenorphine prescriptions increased substantially during the study period for all payers. As noted, the number of prescribers increased by 12.2 percent. The number of NPs who prescribed increased by nearly 80 percent, and the number of PAs increased by nearly 50 percent. The number of patients treated by advanced practitioners also increased substantially. The number treated by NPs increased by roughly 180 percent, and the number treated by PAs increased by 142 percent. Overall, most patients received prescriptions from physicians.

When looking specifically at the Medicaid population, 4 out of 10 patients had a prescription paid by Medicaid, and 6 out of 10 providers prescribed to Medicaid beneficiaries. The number of Medicaid prescribers increased substantially, with higher rates of increase compared to all payers. For example, the number of NPs increased by 121 percent, and the number of PAs increased by nearly 90 percent. The number of physicians increased as well, by 6 percent.

So this figure shows the increases in the number of advanced practitioners, sort of highlighting what we talked about in the previous slide, who prescribe to

Medicaid beneficiaries. This is by prescriber type and by quarter during the study year.

We also observed that advanced practitioners accounted for an increasing proportion of all Medicaid prescribers during the study year. For example, the proportion of prescribers who are NPs increased from 7.2 percent to 13.6 percent. The proportion of prescribers who are PAs increased from 3 percent to nearly 5 percent. Physicians, as a share of all Medicaid prescribers, decreased slightly, from nearly 90 percent to approximately 82 percent, but still accounted for the majority of prescribers.

In this figure we're looking at the proportion of Medicaid beneficiaries with buprenorphine prescriptions from advanced practitioners by state. The rate ranged from 1.2 percent in Alabama to 55.4 percent in South Dakota. States with low rates of prescribing by advanced practitioners for Medicaid beneficiaries were clustered in the South and Southeast, and those with high proportions of prescribing by advanced practitioners were concentrated in the West and Upper Northwest.

In comparing outcomes for the Medicaid population

with those of other payers, we found that the increase in the number of Medicaid beneficiaries with prescriptions was double the increase for all patients, 12 percent versus 6 percent. In addition, advanced practitioners' patient base was more likely than other providers to be covered by Medicaid.

In our comparison of prescribing trends by geographic location we found that nearly 9 out of 10, or 88 percent, of prescribers practiced in urban areas. However, rural areas had a higher proportion of advanced practitioner prescribers, 24 percent versus roughly 18 percent. In terms of trends during the study year, we observed similar increases for Medicaid prescribers in both urban and rural areas.

Not surprisingly, patients were more likely to receive buprenorphine prescriptions from advanced practitioners in states with full nurse practitioner prescriptive authority. Specifically, states with full NP prescriptive authority had a higher proportion of advanced practitioner prescribers. That was 25 percent versus 16 percent.

As another indicator of access to treatment, we

examined whether buprenorphine prescribers were prescribing at or near their patient limit after obtaining a DATA 2000 waiver. As background, prescribers may treat no more than 30 patients in the first year but can request permission to increase this number to 100 patients in the second year, and then a further increase to 275 patients. We found that Medicaid providers were treating more patients compared to other payers but are still prescribing below the initial waiver limit of 30 patients.

The findings from the study indicate that expanding buprenorphine prescribing authority to nurse practitioners and physician assistants through CARA led to substantial increases in prescriptions across all payers, and particularly for the Medicaid population. These findings suggest that policies that expand provider authority for prescribing buprenorphine can increase access to treatment for OUD.

We also note that beneficiaries still face barriers to OUD treatment. For example, only roughly 5 percent of eligible providers have obtained a buprenorphine prescribing waiver. In addition, access to buprenorphine waivered providers varies, with shortages particularly in

rural areas.

In terms of next steps, IMPAQ will be presenting findings from this study at the Association for Public Policy Analysis and Management research conference next week. In addition, IMPAQ and MACPAC staff submitted a post to the Health Affairs blog which has been accepted for publication. We will also be posting the contractor report on our website.

This concludes our presentation on the findings from our study on buprenorphine prescribing patterns among advanced practitioners, and we welcome questions from Commissioners. Thank you.

CHAIR BELLA: Thank you, John. Really important work, very informative. I think as you said and as is noted, there is no action for us here, but happy to spend some time with any questions. Martha?

COMMISSIONER CARTER: Thanks, John, and it's affirming to know that this action on the part of SAMHSA has made a difference in access to care.

It wasn't in your slides but it was in our materials that initially clinical nurse specialists, nurse midwives, and nurse anesthetists were not included in the

first batch of advanced practice clinicians that were allowed to prescribe. And I think that happened -- now I don't have the dates in front of me -- that happened a couple of years, or just recently, that this group -- clin specs, nurse midwives, and nurse anesthetists, CRNAs -- were allowed to prescribe.

There may actually be nurse midwives in your sample of nurse practitioners, because some nurse midwives are also nurse practitioners, either family nurse or women's health nurse practitioners, and because some states consider nurse midwives to be nurse practitioners, so it depended on how they applied.

But this group only got a time-limited approval. They only got a five-year approval to prescribe buprenorphine. So I was wondering if you can pull out, in your data, any of these other types of practitioners, you know, to help support their attempts to get permanent authorization, as nurse practitioners and PAs do.

Did my question make sense?

DR. WEDELES: It did. It did.

COMMISSIONER CARTER: Okay. A little rambling. Sorry.

DR. WEDELES: That's okay. That's okay. We can go back to the data and see if that's possible.

COMMISSIONER CARTER: I mean, it makes sense that if we're seeing good results with nurse practitioners and PAs that especially nurse midwives, who care for pregnant women with addictions, and all these other categories of advanced practice nurses, would have similar outcomes.

EXECUTIVE DIRECTOR SCHWARTZ: But, John, isn't it correct -- I mean, the expansion happened in the SUPPORT Act, right?

DR. WEDELES: Right.

EXECUTIVE DIRECTOR SCHWARTZ: Which passed last October, and I don't know exactly when it was effective. And we only had the data for the period here. So we wouldn't be able to look at the expansion to those additional practitioners without buying an additional, very expensive --

COMMISSIONER CARTER: No, that wasn't exactly what I was asking. I believe they are probably already, at least nurse midwives, in your first sample.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah.

COMMISSIONER CARTER: Because they would have

come in as nurse practitioners.

EXECUTIVE DIRECTOR SCHWARTZ: I see. Okay. Sorry.

COMMISSIONER CARTER: So, you know, any data to support eliminating the time limit of five years that this group got authority to prescribe.

CHAIR BELLA: Peter, then Chuck.

COMMISSIONER SZILAGYI: Yeah, very nice, John. Just a quick clarification question from me. I noticed that you described how the proportion of buprenorphine prescriptions from NPs or PAs are rising, although physicians are still the majority. Have physicians dropped out because of this? I couldn't tell whether the numbers of MDs who are prescribing have actually gone down. Is there replacement, in other words, now that nurse practitioners and PAs can prescribe?

DR. WEDELES: Well, I think the number of physicians went up over the study year. It was just the proportions that adjusted slightly.

COMMISSIONER SZILAGYI: So the numbers are still going up, of MDs?

DR. WEDELES: Yes. Yes.

CHAIR BELLA: Chuck, and then Fred.

COMMISSIONER MILLIGAN: Thanks, John. Two questions. I have a feeling that the answer to both is that we don't know and it was kind of out of scope, but I want to just frame them up in case others pick up this research. A lot of times prescribing bupe also needs to be supported by, you know, therapies and other kinds of things, and so one of the questions I have a feeling we don't know is the extent to which there might have then become a pent-up demand or access issues about just the support for dealing with addiction itself, in terms of behavior change, coming out of more people accessing bupe.

The second question, and related, is there is a lot of correlation between individuals with this kind of addiction and hepatitis C, and again, I'm wondering whether we know anything about the extent to which having more access points and having more access to services and prescriptions has led to more referrals or other treatment for related conditions like hepatitis C? And again, I suspect for both of those it was probably out of scope, but I wanted just to frame up the question.

DR. WEDELES: Sure. So for the first part of

your question, you're referring to demand for behavioral services, for therapy services, or for the buprenorphine treatment?

COMMISSIONER MILLIGAN: Yeah, and maybe -- my information might be a little bit dated, but I know that when we expanded bupe in Maryland, when I was the Medicaid director, a lot of it was also meant to support dealing with addiction itself, so that people could find a way to, you know, kick it and get clean and recover. And if there are more people getting access to bupe, are they getting access to the supportive services to deal with the addiction itself, or are we creating pent-up demand for the kind of related services necessary to deal with addiction, as a behavioral health condition?

But again, I have a feeling that we didn't kind of get into that with this, but I do think that those are -- both the hepatitis C piece and the therapy support piece are important aspects of having more entry points for access to bupe itself.

DR. WEDELES: Yeah. So I would say both of those, you know, the hepatitis C treatment and then the behavioral therapies were outside of the scope of this

study, but I think, you know, when you look at the results, one takeaway is that, you know, there may have been pent-up demand for -- again, we were just looking at the medication side of the treatment. So, you know, through this policy you expand prescribing authority and more people who are able to provide the treatment, and more providers are taking that opportunity, more patients are being treated, so it would suggest there was a pent-up demand for that, sure.

COMMISSIONER CARTER: Can I -- like Bill says, follow the money. You know, if the state Medicaid program is paying for especially counseling services, you are probably more likely to see that. And, you know, if you've got means to treat hepatitis, once you've diagnosed it, you're more likely to see that. So just a general comment about your question.

COMMISSIONER MILLIGAN: Your honorary economics degree is coming into play at this point, Martha. Thank you.

CHAIR BELLA: Fred, then Sheldon, then Toby.

COMMISSIONER CERISE: One of the complaints I hear from people that work in this area are the limits that

you can prescribe -- 30, 100, 275. The number you put out here don't indicate that that's much of an issue, with the medians being less than 20 for prescribers. As you look at the data, is there a significant group, though, that is at that extreme, that's bumping up against the cap there, or does that not really show up as an issue? Do you know what I'm saying?

DR. WEDELES: You're referring to the provider type?

COMMISSIONER CERISE: Yeah. Well, not necessarily the provider type, but is there any group, or is there a substantial population of providers, whether it's physicians, NPs, PAs, that are clustered at that far end, that are restricted by the cap? Because this would indicate that's not much of a -- you know, there's not much of a complaint there.

DR. WEDELES: Right. Right. I think physicians, they were treating the largest number of patients, but I should sort of caution taking away too much from that measure. It was, you know, as we acknowledged, an imperfect measure for looking at patient load, and it's difficult to measure that. It's difficult to know sort of

what the patient limit is for providers. So, you know, how soon or how recently did they obtain the waiver, so sort of what limit they're -- you know, what limit is applicable to them.

So, yeah, you know, I hesitate to take too much away from that, but I think physicians were treating the largest number of patients, compared to the other types of providers.

COMMISSIONER BURWELL: [Off microphone.]

CHAIR BELLA: It grows over time. Sheldon.

COMMISSIONER CARTER: Kisha knows this, but I think -- I don't think it's per year. It's concurrent. It's concurrent, so you can have 30 patients at any one time. And so the tension is not going over your 30 patients at any one time. You want to speak?

COMMISSIONER DAVIS: Right. It's total --

COMMISSIONER CARTER: We're really having a free-for-all here. I apologize.

COMMISSIONER DAVIS: -- it's total number. So 30 and then you can apply to 100 and after that you can apply to be able to have 275. But I think the problem is a lot of people just aren't applying.

COMMISSIONER BURWELL: [Off microphone.]

EXECUTIVE DIRECTOR SCHWARTZ: So, John, wouldn't it be fair to say we had pharmacy claims for a year? So this doesn't tell you necessarily how many patients a particular practitioner would be caring for. Because you could have somebody that was in treatment and then they are no longer with them, but we still be counting them all up. So it's not a great data set for that issue.

DR. WEDELES: Right.

CHAIR BELLA: Sheldon.

COMMISSIONER RETCHIN: I think it's a nice piece of work, and just wonder -- but let me be clear on this. So CARA, the Recovery Act, allowed the expansion of prescribers who could autonomously prescribe buprenorphine, or it was under the whatever the state scope of practice restrictions are, right? It's B.

DR. WEDELES: Right. Right. Yeah, and that's an important point.

COMMISSIONER RETCHIN: Okay. So here's an exogenous shock of policies that would be interesting to follow, because now you have states that have restrictive scope of practice laws that CARA now is sort of indicated,

but still they have to function that way, and the others that have a much more relaxed and increased in -- there would be an increase in access. There must be outcomes we could follow. I don't know how profound that is. But like when you said that 97 percent are still prescribed by physicians, I'm sure that's true. But then you look at the states with restrictive scope of practice and those without, and my bet is those numbers vary a lot. And we probably would see something, whether it's opiate withdrawals come to the ER, and that would be an important reflection on the effects of a policy.

And just to add on to that, I'm struck every time we talk about it, how here is an area, an epidemic, in a rural area of the U.S., physicians can't possibly serve it and most don't want to, and yet there's still a scope of practice obstacle that is just baffling. But here's an example where we really could comment on the effects of the policy.

CHAIR BELLA: Toby.

COMMISSIONER DOUGLAS: A couple questions, John. One, this goes back to when we were exploring this in California. There was the balance between methadone

utilization and bupe, and I don't know if you can look at an analysis of were there any reductions in methadone utilization during this period of time as bupe went up?

DR. WEDELES: So the data set was limited to prescriptions for buprenorphine, so we couldn't do that particular analysis with this data set.

COMMISSIONER DOUGLAS: Okay. It would be something in the -- because part of it was that accessibility and ability to get outside the actual centers to create better access.

The other question is just understanding the intersection with a lot of the 1115 waiver. It kind of gets to Chuck's question. I know you looked at certain state authorities on NPs, but if there were other -- if it was any relationship to what states were doing overall, the growth increase.

DR. WEDELES: We didn't, not for this study. It was really -- when we were looking by state, it was by the state scope of practice laws.

CHAIR BELLA: We'll turn to the public for any comment.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Any additional comments from Commissioners? Martha, your light is on. Are you wanting to talk?

COMMISSIONER CARTER: I probably have more to say but not right now, thank you.

EXECUTIVE DIRECTOR SCHWARTZ: I think what I heard is that the blog is going to come out on Wednesday, and we'll send you the link to that when it comes out, and then we'll also send you the link when we put up the full contractor report, which is multiple -- many more pages long, so you can totally geek out on that when we post that.

CHAIR BELLA: John, thank you. As always, one set of analysis leads to a lot more questions, so to be continued, I think, the discussion in this area. But this is really helpful analysis. Thank you.

We are going to take a quick break. If I could ask everyone to be back at 2:30, we will reconvene then. Thank you.

* [Recess.]

CHAIR BELLA: All right. We're ready to

reconvene, please. Chris, we are anxiously awaiting your update on T-MSIS, so we are ready whenever you are.

UPDATE ON TRANSFORMED MEDICAID STATISTICAL INFORMATION SYSTEM (T-MSIS)

* MR. PARK: Sure. Thanks, Melanie, and, you know, T-MSIS will solve everything. So we're getting to that point.

So in previous report chapters, we have commented about the importance of federal administrative data, which are critical for administration and oversight of the program for Medicaid and CHIP. Today I'll provide an update on the Transformed Medicaid Statistical Information System, or T-MSIS. T-MSIS is the only federal source for recent information on eligibility and spending at the person level. I'll provide some background information on the implementation of T-MSIS as well as an update on the availability of these data. MACPAC has recently obtained access to T-MSIS, so I'll go over some of our ongoing work to assess the quality and completeness of the data. And, finally, I'll discuss some of the potential future work we may want to do to examine new or improved data elements that provide information that was not previously available.

T-MSIS is a part of several CMS initiatives over the past few years to improve data collection. It replaces the Medicaid Statistical Information System, or MSIS, as the only federal data source for person-level information on eligibility, demographic, service use, and spending. T-MSIS builds on the existing MSIS data to improve the timeliness, reliability, and completeness of data.

CMS and states have been transitioning to T-MSIS over the past few years; however, this process has been slow. Implementation first began in 2013, but it has been delayed for several years due to ongoing technical and operational challenges.

Here are just a few examples of how T-MSIS looks to improve on the MSIS data. MSIS data was submitted quarterly while T-MSIS is submitted monthly. MSIS only had a few automated quality checks while T-MSIS has over 2,000 automated quality checks. MSIS only have 400 data elements, and T-MSIS has about 1,400 data elements. So, you know, not only does this include new data elements, but some of the existing elements were expanded in terms of the range of information collected.

So, for example, T-MSIS now includes over 60

Medicaid eligibility categories to only nine in MSIS, and the T-MSIS categories include separate groups for individuals eligible on the basis of pregnancy and the new adult group. Those categories were previously indistinguishable under the adult basis of eligibility codes in MSIS.

Also, T-MSIS includes three new data files on providers, managed care organizations, and third-party liability.

States began implementing T-MSIS in 2013 on a rolling basis. States stopped submitting MSIS during this transition. This end of MSIS reporting coupled with the delays in T-MSIS data have created a significant gap in data over the past few years. To fill in this gap, states were instructed to backfill T-MSIS data back to the point where they stopped submitting MSIS data. However, this creates some challenges that I'll discuss later.

In 2018, CMS announced that all states are submitting T-MSIS data, and as of August 2019, all states except one are current with their submissions; that is, they have submitted data through the most recent month.

CMS has also identified 12 top priority items for

states to address and has been working with them to improve quality in these areas. CMS issued an informational bulletin this past March with the expectation that states resolve these data issues and submit improved T-MSIS data for inclusion in the first T-MSIS public data release.

T-MSIS data is available in different forms, so I just want to go over some of the different terminology and the key differences between these data sets.

The first is the raw T-MSIS data. These are the data that states submit directly to CMS and include eligibility records and claims adjustments as well as the original records. These data will not be publicly available, but are available within CMS and to certain federal agencies.

CMS is going to take the raw data and standardize it around the calendar year into a research ready file called "T-MSIS Analytic File," or TAF. The TAF streamlines information by collapsing the eligibility information into a single record for each person and identifies final paid claims.

These TAF files are further refined for public dissemination. The public version of TAF, also called the

"TAF Research Identifiable Files," or RIF, including additional adjustments such as removing certain personally identifiable information as well as removing payment amounts made by the managed care plans under encounter claims. The RIF will be the replacement for the Medicaid Analytic Extract, or MAX, files that were previously available for researchers.

CMS has announced that the RIFs for calendar years 2014 through 2016 will be released in November, and as a part of this data release, CMS is also developing data quality briefs on the 2016 data to support users of these files. The data quality briefs include information on certain priority field such as eligibility group, includes statistics on file usability, the percent of values that are missing, as well as benchmark comparisons to various data sources such as enrollment from the performance indicator data.

As I said previously, MACPAC has obtained access to raw T-MSIS data, and we're currently in the process of analyzing the data for completeness and accuracy and assessing its usability to update exhibits in our MACStats data book that were based on the old MSIS data.

As of now, fiscal years 2014 and 2015 are not reliable, and this is due to a couple of reasons. First, there were issues during the first couple of years of T-MSIS implementation. While CMS and states have worked to correct these issues, these improvements have been focused on more recent time periods, and it's not clear that these corrections were made going back to the data for 2014 and 2015.

Additionally, due to the rolling implementation of T-MSIS, all states do not have T-MSIS data going back to the same starting date. And the data for some years, you know, 2014 and 2015, may be split between MSIS and T-MSIS. So this creates a particular challenge since the differences between the data sets make it challenging to combine the two data sources for a fiscal year and maintain consistency in how certain beneficiary characteristics or service categories are reported.

All states have T-MSIS data going back to October 2015, so we do have data for a complete data source in T-MSIS for fiscal year 2016.

Our first tests have been focused on the number of Medicaid enrollees reported by state and eligibility

group in fiscal year 2016, and we've been benchmarking the numbers out of T-MSIS to different benchmarks. For total enrollment and enrollment for the new adult group, we've benchmarked the T-MSIS data to enrollment that states have reported on CMS-64 forms. But because the CMS-64 enrollment reports do not break out enrollment by eligibility group other than the new adult group, we've been using old MSIS data from 2012 and 2013 by eligibility group that we had used to develop prior MACStats tables.

So here are some preliminary results that we found using our data. Compared to total Medicaid enrollment, which is the left column, we found that about 43 states had T-MSIS data that produced good alignment to total enrollment found on CMS-64 reports, and eight states had poor-quality data. Of the 43 states that had pretty good data based on the total enrollment, we then looked at whether these states had good alignment on the enrollment for the new adult group. And 39 states had good alignment on the new adult group and four states had some discrepancies, which generally meant that they were not separately identifying the new adult group from other adults in the T-MSIS data.

Then of those 39 states, we then looked at how enrollment compared between the T-MSIS data in the 2012 and 2013 data by the other eligibility groups. And of those 39 states, 25 states had good alignment with the other eligibility groups, one state had poor alignment, and 13 states had either a change in the absolute number of enrollees or the percentage of enrollees across those different eligibility groups that were a little bit unusual, and we want to do some more investigation as to whether these changes are reasonable.

So what this means is that our preliminary results indicate that we may only be able to use fiscal year 2016 data from about 25 to 38 states. We are still in the process of calculating spending by eligibility group from the T-MSIS data, and we will compare that to spending from prior years' MSIS data as well as the CMS-64 data. So once we take spending into account, the number of usable states may change. Additionally, states and CMS have been continuously working to resolve data issues, so the number may also grow in the future as they resolve these issues.

Due to the number of questions still remaining on enrollment as well as the ongoing work we need to do to

validate the spending information, we will not update a number of MACStats exhibits that rely on the T-MSIS data s we won't be able to do that in time for our December 2019 data book publishing deadlines. This affects nine exhibits where we will just reprint the 2013 and 2014 data that we had previously published.

After we validate the core variables required to calculate enrollment and spending by eligibility group, we can review additional variables that will be of interest for future analyses. We expect that work will be ongoing over a long period of time. These variables will include some that we have used in previous analyses such as diagnostic codes, procedure codes, DRGs, and provider information such as provider taxonomy. In addition, we want to explore certain payment variables that may allow for new research on topics where information was previously limited or not available. This will include looking at whether the payment amounts are available on managed care and encounter claims, on service tracking claims. Service tracking claims include lump sum payments such as supplemental payments, drug rebates, and other things that may not be identifiable to a particular person but paid in

aggregate. As well, we will want to check to see whether the funding source has been identified for various payments to providers. So this would indicate whether the payment was funded by like a provider tax, intergovernmental transfer, or certified public expenditure.

Additionally, we will want to explore -- see what detailed information are available on different service classifications. For example, it was difficult to identify specific home and community-based services in the MSIS data. There is a waiver type variable which indicated whether an enrollee was enrolled in a 1915c waiver and a program type variable that identified a claim as being related to HCBS but didn't necessarily give you any information on the specific type of services provided. The type of service on these claims were just classified as "other services."

So in T-MSIS, the waiver type and program type variables are still available but provide further classification options. Furthermore, the single category that was called "other services" in MSIS under type of service now maps to 33 unique services, including several classifications of HCBS. Additionally, there are several

new variables that address HCBS identification, including HCBS service code, HCBS taxonomy, benefit type, as well as CMS-64 category, which will help us map the data from T-MSIS to the actual spending reported on the CMS-64. So these fields may provide very detailed information on the type of HCBS services provided such as adult day health, habilitation, case management, or personal care. While this will provide a wealth of new information, we'll need to do a bit of work to kind of identify, you know, which of these variables may be the most relevant for a particular analysis that we're looking to do as well as whether the information is consistent across all these new variables.

And so, with that, I'll wrap up and pass it back to you.

CHAIR BELLA: Thank you for that. I know you were hoping to be sitting there today telling us it was a slam-dunk and MACStats was going to be updated with T-MSIS, but great progress. Thank you. It feels like we're making -- getting close.

MR. PARK: Yeah, we're probably closer than ever, but still, you know, questions remain.

CHAIR BELLA: Yes. Well, Sheldon?

COMMISSIONER RETCHIN: Yeah, Chris, you make a good poker player. I'm trying to figure out if you're content and optimistic or really just kind of down and depressed about it.

[Laughter.]

COMMISSIONER RETCHIN: But that's okay. Don't tell us.

Can I just ask, will this T-MSIS include a linkage with vital status file so we'll be able to look at mortality rates?

MR. PARK: There might be some ways to do that using kind of the raw data where it will have some personally identifiable information that, you know, could potentially be able to link toward other data sets. But I'm not quite sure at this time.

COMMISSIONER RETCHIN: Okay.

CHAIR BELLA: Did you have another question?

COMMISSIONER RETCHIN: No.

CHAIR BELLA: Stacey, then Tricia.

COMMISSIONER LAMPKIN: So, you know, we've talked before about the challenges with never having perfect data and being able to decide what you can do realistically and

practically with the data you have and appropriately characterize it. I'm curious about how we're thinking about these validations in terms of when it's good enough, so when you showed us the bar graph and you classified states as "good," were you using a threshold percentage? And how are we thinking about that at a high level, not a detailed level?

MR. PARK: Yeah, sure. Generally, where we were identifying states as "good" is that they were within plus or minus 10 percent of the benchmark. So the good states were, you know, plus or minus 10 percent on total enrollment compared to CMS-64. So that was kind of our benchmark for "good."

Where we started having questions and not necessarily a clear benchmark but it was more just, you know, trying to get a feel for what was happening is, like, when we were comparing to the 2012 and 2013 data, because, you know, it shouldn't match exactly. You know, we're trying to assess whether like there are significant increases; like one group enrollment increases like 30 percent or goes down 30 percent, we would flag that as questionable. If the distribution between like children

and adults, disabled and the aged were significantly off, you know, now all of a sudden the adults were 30 percent of the population where they were 15 percent in 2012, and we know the state didn't really do anything to expand or contract eligibility, then that's where we're kind of flagging it as questionable.

CHAIR BELLA: Tricia.

COMMISSIONER BROOKS: Thanks, Chris. I'm glad that we have another set of eyes on this data, and I'm sure your work is help to CMS as well. I'm just a little confused about the graph on Slide 8 in terms of the number of states. I mean, I can understand going from the first, which is 51, to the second because not every state has adopted the adult group. But then we don't have as many states in that next group, so I'm just confused why that total number is lower.

MR. PARK: Sure. So, you know, it was kind of -- you know, we were doing this kind of in a step-wise fashion. If the states were bad on total enrollment, we didn't necessarily -- you know, we would consider them "bad" once we started looking at it by eligibility group. So, you know, we went from 43 states identified as "good."

Within those states, you know, did they also break out the new adult group in the T-MSIS data, and did that compare to the CMS-64 data? So, you know, the 43 states there would also include states that didn't expand because there was no matching there. And so once we saw that the states kind of matched on those two, like total enrollment, then the new adult group enrollment, then we started testing to see, okay, well, do they kind of make sense on the other eligibility groups where we didn't have the 64 data.

COMMISSIONER BROOKS: Great. That explains it well. And those counts are based on what year of data?

MR. PARK: This is the 2016 data.

COMMISSIONER BROOKS: It is still 2016. Okay. Thank you.

CHAIR BELLA: Brian.

COMMISSIONER BURWELL: What level of confidence do you have that CMS will release the RIF files in November?

MR. PARK: They have announced that publicly at the MESC conference a few months ago, so I think that is their intention. You know, we've been talking with CMS, and it does seem like that is their -- you know, they

definitely want to do that in November. They've acknowledged -- you know, and one of the reasons for these data quality briefs is that it's acknowledging that the data are imperfect and trying to help potential users get a sense of, you know, whether the state has good quality compared to the different benchmarks.

We did see that last week CMS released the SUD data book which was based on T-MSIS data using 2017 data, and they also acknowledged, you know, some of those discrepancies, and they included some of the data quality briefs they're developing for 2017 with that data book. So I think their point of view is we're going to release this data, we're going to try to give as much information to people as possible, but they're not going to wait until it's perfect.

COMMISSIONER BURWELL: So here are the 2014 to 2016 data. So here are these data quality briefs which you should read.

MR. PARK: That's correct.

COMMISSIONER BURWELL: You know, that will impact your analytical work.

MR. PARK: That's correct, yes.

COMMISSIONER BURWELL: When do you think 2017 data will be available?

MR. PARK: From what we've heard, you know, I think they're contemplating, when we last talked to them, you know, whether or not they are going to try to do another data quality push for the states. So I think it probably won't be until sometime early next year before they would release the 2017 or 2018 data.

COMMISSIONER BURWELL: Data quality means those that didn't pass [off microphone], sending them back to the states?

MR. PARK: Right. As I mentioned, they had identified these priority areas. Some states may not have like fixed all the issues in the priority areas, so, you know, they've been continuously working with the states on those issues, and so I think they are trying to see if they wait another few months, can they make a significant -- at least for a few states maybe where there are still issues, can they improve that?

COMMISSIONER BURWELL: Last question. I know that we were among a group of kind of early adopters or early users. Does that group still meet and share

information about what --

MR. PARK: That group that CMS has put together is no longer meeting. You know, that was trying to get some information to help develop these research files. That doesn't preclude any type of user group from forming in the future, though.

COMMISSIONER BURWELL: But are we in touch with -- I mean, if there are other organizations like us that are also looking at these --

MR. PARK: Sure. Most of the people who are using the data right now are internal CMS users, like the Office of the Actuary. So, you know, we've talked to them about what they're finding, so we're definitely keeping in touch. We've been working with Mathematica, who's one of CMS' contractors, to look at this data. So we're trying to keep, you know, in touch with all the various parties.

CHAIR BELLA: Darin.

COMMISSIONER GORDON: Chris, thank you. This is very helpful. A question: When the state submits the data, does it have to pass any kind of threshold edits? Or do they accept the entire submission even with some of the errors? Or do they, you know, basically spool off those

areas that didn't pass any edits and have states resubmit that? I'm just trying to understand, when we look at data, is -- that process could influence when we see massive changes over a period of time.

MR. PARK: Yeah. I mean, as I mentioned in the presentation, there are certain automated quality checks that the data have to go through, which generally means is that field filled in. Does it fit a procedure code? Does it kind of match up to what you would expect, the right number of characters and numbers? But I don't know every single quality check that may happen before it's rejected.

But then I think there's also some -- particularly right now, as the data is being tested and improved, that Mathematica is working with CMS on these data quality briefs to help them kind of assess the quality against benchmarks, and this is kind of where they're probably identifying progress on these priority areas, going back to the states saying, "We expected enrollment in these 20 mandatory categories. You only have enrollment in 10." Does that make sense?

COMMISSIONER GORDON: Yeah. I saw your point and heard your point on the automated quality checks. My

question is, Are they still accepting that into the broader database for which we all would need to understand or analyzing it that, yes, we've accepted all of that in with these known issues, or are they rejecting it if there's a certain threshold of those automated for which the data submission does not pass in asking for a resubmission?

MR. PARK: Yeah. I would have to go back and check with CMS as to kind of what the thresholds are for rejection. I'm sure that there -- like some of those quality checks would kind of reject the state submission because this field is completely blank, that type of thing, but I would need to kind of --

COMMISSIONER GORDON: It's helpful to know. We had, in the early years, very primitive systems where we just rejected it if you didn't hit some arbitrary thresholds and basically would lose even the good data. But, in time, we're able to just address those issues that had it, edit, or didn't pass the editing, kick them back to get corrected, but still get the majority of the information in the system for analysis. It's just helpful for me to understand when we're doing analysis, how they approach that.

MR. PARK: Sure. And I think probably they're not rejecting the data for some more detailed field that may not be immediately -- like the CMS-64 service category, they might not reject it because that's not filled in correctly, because you still have like a correct type of service category on it.

So I don't think they are automatically rejecting if every single field is not correct. I think they are giving certain allowances for -- if it's not a priority item at this point, they might get certain allowances not to expect complete data. Yeah.

CHAIR BELLA: So, Chris, just a couple last questions. I know we're working most directly with Mathematica, but will we have an opportunity or would we want the opportunity to talk directly with states at any point now that we're in this process?

And secondary to that, do they know where they are? Would these 13 states know that they've been graded as questionable, or would this one state know that it's poor? Do the states think they're doing better than they are, or is it pretty evident, or do you know?

MR. PARK: I know CMS has been working closely

with states particularly on these 12 priority items, and I've seen a chart. I don't know if it's public, but it kind of showed where each state was related to progress on those priority items, like how many issues they still had outstanding.

I know CMS has been really working closely with the states. I don't know to what extent that they know that the very specific issues of like these 13 states, where you might flag them as questionable right now. As I said, we need to do some further research.

So I don't know to what extent CMS might be doing the same level of detailed analysis.

CHAIR BELLA: Do we have any questions or comments from the public?

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Any other questions or comments from Commissioners?

[No response.]

CHAIR BELLA: All right. I think we file this in the stay tuned category, right, Chris?

MR. PARK: Yes, that's correct.

CHAIR BELLA: All right. Thank you very much.

It would not be a MACPAC meeting if we didn't have DSH, and so we're going to finish out the day with an update on DSH. And I think we're preparing for a draft chapter in December, correct?

All right. Ryan, welcome. Thank you.

REQUIRED ANALYSES OF DISPROPORTIONATE SHARE HOSPITAL ALLOTMENTS

* MR. GREENFIELD: Good afternoon. Today I'm going to talk about the statutorily mandated data elements related to the Medicaid Disproportionate Share Hospital program. As we've done in past years, these analyses will also be included in the Commission's March report to Congress.

So, as a reminder, under the Medicaid statute, states are required to make supplemental payments to hospitals that treat a high proportion of Medicaid and low-income patients. These payments are intended to offset the costs of hospitals providing care to individuals who may be unable to fully reimburse the cost of the services they receive.

MACPAC is required to report annually on a

variety of data related to Medicaid DSH.

So, today, I'll describe changes in the number of uninsured individuals between 2017 and 2018, provide the latest data related to the amounts and sources of hospital uncompensated care, and describe the subset of these hospitals that provide essential community services such as obstetric care.

Finally, I'll provide updates on the DSH allotment reductions scheduled for Fiscal Years 2020 through 2025 as well as highlights from the final evaluation of California's Global Payment Program demonstration, which established a value-based approach to DSH payment.

So starting with the uninsured, first, according to data from the U.S. Census Bureau, 27.5 million individuals were uninsured in 2018. This represented 8.5 percent of the U.S. population, and it was an increase of 1.9 million individuals from 2017.

This was also the first statistically significant increase since 2009.

With regard to the changes in insurance coverage, there were 2 million fewer individuals enrolled in Medicaid

and CHIP, but there were no statistically significant changes in other forms of public or private coverage.

This table provides some highlights in the changes in the uninsured rate broken down by certain characteristics. As you can see on the farthest right column, there were statistically significant increases in uninsured children as well as adults below age 65, with uninsured rates increasing by 0.6 and 0.8 percentage points respectively.

We also observed a statistically significant increase in uninsurance for individuals of Hispanic origin, and then the uninsured increase was also statistically significant for individuals with incomes above 300 percent of the federal poverty line.

Finally, in terms of Medicaid expansion status, the uninsured rate in 2018 was nearly twice as high for non-expansion states as in expansion states.

So next, moving on to uncompensated care, first, it's important to note that DSH payments can cover the unpaid costs of care for both uninsured individuals and Medicaid shortfall. The most recently available data on hospital uncompensated care comes from the Fiscal Year 2017

Medicare cost reports, which defines uncompensated care as charity care plus bad debt.

Hospitals reported a total of $39.9 billion in uncompensated care in 2017, which represented 4.3 percent of hospital's operating expenses. This also represented a $2.7 billion increase from 2016, but only a 0.1 percentage point increase as a share of operating expenses.

Amounts of uncompensated care also varied widely by state in the aggregate. For example, hospitals and states that did not expand Medicaid reported that uncompensated care represented 7.2 percent of their operating expenses compared to 2.8 percent in expansion states.

So Medicaid shortfall is the difference between a hospital's cost of care for Medicaid-enrolled patients and the total payments it receives for those services. So because the Medicare cost reports do not include reliable information on Medicaid shortfall, we used the annual American Hospital Association Survey to provide a national estimate.

The latest AHA survey indicates that Medicaid shortfall totaled $22.9 billion in 2017, which was an

increase of $2.9 billion from 2016.

Medicaid DSH audits provided detailed information on Medicaid shortfall, but the latest data are for 2015 and only available for the hospitals that receive DSH payments, which are 45 percent of hospitals.

As a result of the ongoing litigation about the DSH definition of Medicaid shortfall, many states have changed how they report Medicaid shortfall on DSH audits. The commission previously discussed this issue, and MACPAC recommended a statutory clarification to exclude costs and third-party payments for Medicaid-eligible individuals for whom Medicaid is not the primary payer in its June 2019 report.

While the D.C. Court of Appeals subsequently ruled in August that CMS can enforce its prior policy requiring states to count third-party payments for Medicaid enrollees, there is still legal uncertainty.

So we can quantify the effects of the changes for the 21 states that reported third-party payments on their DSH audits. Among these states, excluding the payments from Medicaid shortfall, more than doubled the amount of uncompensated care reported by the DSH hospitals in those

states.

So the table on this slide demonstrates that the effects of not counting third-party payments has different effects on different types of hospitals. The final column of this table shows the increase in uncompensated care reported as a result of excluding the third-party payments.

Compared to the 124 percent increase in uncompensated care reported for hospitals overall, children's hospitals reported a much larger increase of 232 percent. This is likely because children's hospitals serve a high share of Medicaid-eligible patients with private insurance, including many low birth-weight babies.

Because many states distribute DSH based on the amount of uncompensated care reported on DSH audits, these changes could affect the distribution of DSH payments across hospitals.

So for the final statutory requirement, we use data from the Medicare cost reports and the AHA annual survey to report on the number of deemed DSH hospitals that provide essential community services using the same definition MACPAC has used in prior years. We found that among all deemed DSH hospitals, 91 percent provide at least

one essential community service, and 57 percent provide three or more of these services.

Given the Commission's interest in maternal health, this year we analyzed additional individual on the DSH hospitals that provide obstetric care, which is one of the essential community services included in our definition.

DSH hospitals are generally required to have two obstetricians serving Medicaid patients on staff in order to receive DSH payment, but rural hospitals can satisfy this requirement with non-obstetric physicians who can perform deliveries. We found that rural DSH hospitals were less likely to report having an obstetric care unit than urban DSH hospitals in 2015. In addition, most rural DSH hospitals with obstetric care units only provided services for uncomplicated deliveries, while urban DSH hospitals provided a higher level of obstetric services.

So turning to the DSH allotment reductions, the DSH funding, as you know, is limited to state-specific federal allotments that totaled $12.6 billion in Fiscal Year 2019.

Under current law, federal DSH allotments are

scheduled to be reduced by $4 billion in Fiscal Year 2020 and then $8 billion in each of the Fiscal Years 2021 through 2025.

The Continuing Resolution enacted in September delays the DSH cuts for the current year from taking effect until November 22nd but does not change the overall size of the reduction.

While prospects for further legislative action are uncertain, Congress has repeatedly delayed the DSH cuts from taking effect since they were initially scheduled for Fiscal Year 2014.

The Affordable Care Act required a reduction methodology that distributes the largest cuts to states with lower uninsured rates and to states that do not target their DSH payments to hospitals with high uncompensated care and Medicaid patient volume.

The CMS methodology, which was finalized last month, is largely similar to the methodology that was proposed in 2017. As MACPAC's previous analysis indicated, this methodology will not meaningfully change the -- improve the relationship between DSH allotments and levels of hospital uncompensated care or any other factors that

Congress has asked MACPAC to consider.

The Commission also made recommendations to improve this relationship in the March report to Congress.

So, finally, given the Commission's interest in value-based approaches to DSH payment, we reviewed the final evaluation of California's Global Payment Program, or GPP. The evaluation was released in June.

For background, in December 2015, California received approval for Section 1115 demonstration to distribute DSH funding as part of a global payment that incentivizes hospitals to reduce avoidable hospital use.

The state was able to claim the costs of physician services and other non-hospital costs that would not normally be coverable under DSH.

Overall for the health systems participating in the GPP, these nonhospital costs accounted for about half of all uncompensated care reported in the demonstration's baseline year.

The health system payments were also structured so that in later years of the demonstration, potentially avoidable services, such as emergency department visits, would earn a smaller share of the global budget.

While data were only available through the first three years of the demonstration, the evaluators noted several outcomes that were mostly positive and in line with the goals of the GPP. These included improved care coordination and data collection, an increase in access to services for the uninsured, and a reduction in avoidable hospital use, including a 14 percent reduction in emergency department visits and a 15 percent reduction in inpatient hospital care.

While other states can apply for Section 1115 waivers to implement approaches similar to California's GPP, we're not aware of other states that are currently interested in such approaches, and states may not be inclined to make changes to their DSH policy, given the uncertain around DSH funding at this time.

So, in terms of next steps, the Commissioners' feedback on the analyses presented today will be incorporated into the draft of the March 2020 report to Congress, which we'll present at the December Commission meeting. The chapter will include additional information on DSH payments and the characteristics of DSH hospitals, similar to what's been included in prior reports.

Staff will also continue to monitor congressional action on the DSH allotment reductions and will update its projections of DSH allotments accordingly.

So that concludes my presentation, and I'm looking forward to your feedback and happy to answer any questions.

CHAIR BELLA: Thank you, Ryan. That's very comprehensive. Much appreciated.

Sheldon?

COMMISSIONER RETCHIN: That was a great presentation. It sort of reminds me of the movie "A Star is Born," like a senior, older mentoring a younger star.

[Laughter.]

COMMISSIONER RETCHIN: Anyway, way to go, Ryan.

I've been saying this, and we're kind of waiting for this to come up, and I mentioned to Rob as well that the Global Payment Program, it seems like it's going, going, gone because -- and maybe both of you could comment on this, that because there's so many moving parts and DSH is allotted to be reduced that we won't have the opportunity to actually recommend.

Look at what it said, that 51 percent of all

uncompensated care costs were nonhospital. That's extraordinary, and we're missing -- so we're incentivizing these hospitals. Even as the DSH is being cut, we're still incentivizing them perversely to do the wrong thing.

I don't know. Toby, weren't you the architect of the GPP?

COMMISSIONER DOUGLAS: No.

COMMISSIONER RETCHIN: You weren't? Why don't you just say you were?

COMMISSIONER DOUGLAS: I won't take credit. My successor did it. It was hers.

COMMISSIONER RETCHIN: Okay, forget it.

[Laughter.]

CHAIR BELLA: Tom?

COMMISSIONER BARKER: Ryan, I agree that was a great presentation. Thank you.

I wanted to focus on a point you made on Slide 5 about uncompensated care. It says hospitals reported a total of $39.9 billion in uncompensated care costs on Medicare cost reports.

So the Medicare cost report, the Medicare reports on uncompensated care is relatively new. That arose from

the ACA change in Medicare DSH.

I'm just wondering. I think now CMS is pretty confident that that data is accurate. I'm just curious to know what was used before the Medicare cost report to report on uncompensated care. Do you know that?

MR. GREENFIELD: I don't have that information handy. I can certainly circle back with you.

COMMISSIONER BARKER: I'm just curious. Okay.

CHAIR BELLA: Brian?

COMMISSIONER BURWELL: I have a question on Slide 4, uninsured rates by selected characteristics.

MR. GREENFIELD: Sure.

COMMISSIONER BURWELL: Am I correct in interpreting the percentage increase in non-expansion states and expansion states to say that the decline in Medicaid enrollment over this time period was more significant in non-expansion states than expansion states?

MR. GREENFIELD: I wouldn't say that the data on the Medicaid expansion states, part of this slide necessarily speaks to the decline in Medicaid enrollment. I think the key point here is just to show the difference in the magnitude of the uninsurance rate by the different

types of states.

It's also important to note that this data comes from the ACS, whereas the other breakouts come from the Current Population Survey. Based on data availability, we sort of pulled it from the other census source. So you don't see the same increase that you do in the other parts. So the overall uninsured rate showed a smaller increase in the ACS compared to the CPS.

I think the change -- you don't want to look at the change in the uninsured rate specifically, you know, look at that specific cut.

COMMISSIONER BURWELL: Okay.

CHAIR BELLA: Chuck and then Toby.

VICE CHAIR MILLIGAN: Nice job, Ryan.

Two questions. I wanted to start with Slide 6 and just a simple question on the shortfall. Are we on 6?

MR. GREENFIELD: Oh, I'm sorry. Six?

VICE CHAIR MILLIGAN: Yep. Thanks.

So the Medicaid shortfall, I think contextually, when we start preparing this for the March report, I think it's going to be important to link this to the work that we've done previously around supplemental payments because

I think that when we start talking about Medicaid shortfall, is that inclusive of or exclusive of all of the kind of supplemental -- non-DSH supplemental payments that are flowing to hospitals? I think that context is going to be important in terms of how we report this kind of data.

EXECUTIVE DIRECTOR SCHWARTZ: This is inclusive of all the supplemental payments, right?

MR. GREENFIELD: So the DSH audits do include the supplemental payments on them. So the shortfall that we have does reflect that, those payments.

EXECUTIVE DIRECTOR SCHWARTZ: Right.

MR. GREENFIELD: We don't necessarily have the same payments for all hospitals that we have for the DSH, for the DSH hospitals.

EXECUTIVE DIRECTOR SCHWARTZ: Right.

VICE CHAIR MILLIGAN: And so let me try to see if I interpret that part correctly. I'm doing this part from memory. I think when you add the various supplemental payments to the base Medicaid payments, on average, Medicaid payments are a little bit above 100 percent of cost, I think, and if that's the case, then what the shortfall reflects is the fact that there are some

hospitals that, even if they're receiving supplemental payments, are not getting to 100 percent of cost. They're 85 or 90 percent of cost, whereas others might be at 120 or 125 percent of cost.

So I think on average, inclusive of supplemental payments -- and I consulted my technical assistance. I think on average, Medicaid pays above cost, and so partly, the shortfall reflects just disparities among hospitals about whether they're paid up to cost inclusive. Is that accurate?

MR. GREENFIELD: So you're asking if the shortfall takes into account the fact that hospitals, some hospitals receive higher payments than cost?

VICE CHAIR MILLIGAN: Well, if there's a hospital that's getting -- even if they're receiving a supplemental payment, not all of them do, but if they're receiving a supplemental payment and inclusive of that plus their base payment, they're still at 90 percent of cost. There's a shortfall, and so the 22.9 is kind of the aggregation of all of those experiences, whereas some hospitals are paid above cost. Is that -- I'm just trying to -- what I'm trying to do is to link the shortfall figure, which is a

big number, against earlier information we've talked about, which is that on average, Medicaid inclusive of supplemental payments pays above cost.

I don't want to take up too much time. I think as we get ready for the March report, tying those stories together, that narrative together is going to be important because what it sounds like to me is some hospitals are big winners and some hospitals are not. I just think we have to build that narrative a little bit.

MR. GREENFIELD: Yeah, absolutely.

VICE CHAIR MILLIGAN: Okay. The second question is we've been doing the March DSH report for a while, coming out of a congressional requirement, and I do think that not necessarily for today, although if you have it for today, that would be great, but for purposes of the March report, I do think it would be helpful maybe not to write into that, but as it gets presented to us, to give some feedback on how our previous recommendations may or may not have helped the policy environment address the DSH cuts and the DSH issues. I think it would be good from just a good transparency and MACPAC role in all of this to kind of reflect back on where we might have made a recommendation

four straight years, and it just hasn't been picked up, versus a recommendation that maybe has been picked up, just to kind of provide a little feedback to the Commission on how Congress is responding to the information we provide in our report and how it may or may not be useful or used in the legislative debate.

CHAIR BELLA: Can I clarify?

VICE CHAIR MILLIGAN: Sure.

CHAIR BELLA: Are you suggesting we include that in the report? Shall we say, "Congress, you require us to do this annually, and you haven't taken any of our recommendations"?

[Laughter.]

VICE CHAIR MILLIGAN: That is not what I'm saying. We have to send you back to translation school.

But I think for purposes of presenting it here --

CHAIR BELLA: But that's the truth. We're just trying to understand like what --

VICE CHAIR MILLIGAN: I'm trying to figure out, I'm trying to interpret how to take feedback from the policymaking environment on how our DSH reports resonate or become useful, and to me, that might be more kind of

descriptive when it's presented to us and not so much written into the report itself.

I think we should take that feedback, and I'd like to see if we can capture that feedback in that sense. I think that would be informative to us, personally.

COMMISSIONER DOUGLAS: Great job on this.

So, first, on the GPP program -- and it's more posing a question, and we can talk about it another time. Is this again something where we've talked before about the need to really drive more value out of the DSH payments? I know Sheldon has been a big champion of that. Is it something that we should, besides just mentioning it, be a signal, a direction where Congress should be going? So that would be something I think we should just be discussing in the future.

And then the other -- I don't know if it's for Martha. This issue on the uninsured, just seeing the connection to higher income, are any of the analyses looking at whether this is really about on the -- it's just more people moving up the income ladder, if that's the issue, rather than changes in Medicaid policy?

MS. HEBERLEIN: So I don't have the report with

me, but when you look at just the distribution of how many people are in those income buckets, I think some of it -- I have not done the analysis, and I think there are going to be lots of people looking at those numbers. But I think some of it might have to just do with just the number of people in there, where a smaller change would become --

COMMISSIONER DOUGLAS: Significant.

MS. HEBERLEIN: -- more significant.

COMMISSIONER DOUGLAS: Got it. So it's distorting what's really going --

MS. HEBERLEIN: It's possible, and then there's all sorts of other factors. As you go further up the income scales, subsidies aren't available. I think there's all sorts of things that could be going on there that I haven't looked at in lots of detail.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: Just to add a point, on the kids' side, though, we saw the biggest increase was between 138 and 249. Looking at it globally --

COMMISSIONER DOUGLAS: Got it.

COMMISSIONER BROOKS: -- it's a little misleading, and particularly when you're thinking about

expansion versus non-expansion states because, overall, 50 percent of Medicaid is kids, but in non-expansion states, it's going to be 60, 70 percent, depending on the state.

COMMISSIONER DOUGLAS: Yeah. Well, you guys were having a -- are we having time to talk about -- for the report, will there be Chuck's point as well as ideas around -- is that something that is going to come up, or what --

EXECUTIVE DIRECTOR SCHWARTZ: So I guess sort of the bind we're in, I mean, we're in a little bit of a bind thinking about writing something for December, when Congress might take action in December or Congress might take action in February for our March report. I think the issue that we find ourselves in now is we have a requirement to report on these elements.

Basically, the recommendations we have made in this area are, one, we want reporting at the facility level of all the types of payments and the sources of financing to be able to disentangle some of these issues around -- like the distribution across facilities and who is being affected, who is being paid at, above, below cost. So that's a piece. We have mentioned that repeatedly since going back to maybe 2014.

The recommendations that were made last year that were: if you're going to do the cuts, here's a way to affect this relationship between the allotments, the uninsured, and hospital uncompensated care costs. Because nothing has happened, you could say, "We still stand by our recommendations, and if you're going to do those cuts, we still think you should do them this way." That's something you could say.

But in terms of additional analysis, basically the story is still the same this year as it was last year with respect to these data elements, and Congress still hasn't acted. Congress' problem, I would say for me personally, the problem that they have is the distribution across states issue and an issue around should we cut at all, and those are issues that we did not speak to, right? We were sort of saying if you do cut, here's how to do it. And the issue about the distribution of states, we demonstrated it, but ultimately, that's going to be a political issue about whether Congress has the stomach for that kind of thing.

Even though we showed an interesting way to do it, there are still winners and losers because that's just

the nature of that thing.

So, in terms of what you want to say in the March report, other than reporting on the data, we have a timing issue of what happens between now and then. We can play catch-up up to a certain point for our production process. But I don't think there's anything more to say other than what you already said. But if you have some thought about something else, we could entertain that.

VICE CHAIR MILLIGAN: Anne, I'm not quite remembering sequence. In the last March report, had the COB issue with private party insurance come up yet?

EXECUTIVE DIRECTOR SCHWARTZ: So we did that in the June report, and what has happened since June is that the court has ruled, but Congress still hasn't done anything. So that would be another one you might consider.

VICE CHAIR MILLIGAN: Yeah. Because to me, just kind of winging it here, that might be a nice contribution for the March report to say to the extent that this is unresolved in the courts or et cetera, et cetera, this is an area where Congress could take action because I think that that is something consistent with our previous recommendations that hasn't yet then made its way into the

March DSH specific report but has a very important relationship to DSH.

CHAIR BELLA: Toby, did you get your questions answered?

COMMISSIONER DOUGLAS: Yes.

CHAIR BELLA: Fred?

COMMISSIONER CERISE: Yeah. Most of my stuff has been addressed.

I'll just echo some of Chuck's points. I do think the breakdown by categories some sort of the hospitals that are over and under. On Slide 7, you kind of get at some of that and the impact of the compensation rule change. So I agree with trying to shine some light on those differences. This is the reimbursement change but also your earlier point about some categories or hospitals are well above and some are below.

And then I don't know how you work in the payment methodology there, but whether it's funded by IGT or provider fees or whatnot, that has an impact on sort of the net benefits as well, and if there's any way to talk to that, it does kind of round out the story on what the impact on these provider types is, what the impacts are.

Finally, the GPP, I appreciate you putting that in. I think it's a great point. Whether it gets any traction or not, it's a good point, and the fact that it's done as sort of a program, if we just say let outpatient -- physician cost and drugs, include them as allowable costs, you're going to rack up a lot more allowable costs for a bunch of providers. But I like the fact that it's packaged in a program that's got outcomes associated with it and the whole deal, and that's a safer way to make a change in what you could use those funds for.

CHAIR BELLA: So it seems like we should always take the opportunity to reinforce the reporting at the facility level, if that's still the will of the Commission, and I think it has been.

I guess my question is particularly -- it sounds a little bit like we're looking for things to put in the March report because we don't know what's going to happen, but this is pretty standard to what we had last year.

Is it time to revisit the issue of having the allotments based on 1992 spending? I mean, we've looked at that in the past. We haven't brought it up today. I'm not sure why. It's still an issue. Congress doesn't appear to

want to take it up in the context of the cuts. I get that, but should we be looking at that again?

EXECUTIVE DIRECTOR SCHWARTZ: I mean, our recommendations from last year get to that, the rebasing across the states. I mean, from my perspective, if you want to reinforce those recommendations, we can talk about what we were trying to accomplish and encapsulate what we said last year and why we said it and refer them back to it. It does make sense. Like while you're thinking about DSH, remember all these other things that we said about DSH. But that was really the point about the way we did it last year.

I guess there's also a decision point for the Commission going forward. Say Congress acts this fall and either delays the cuts again, in which we sort of have the same scenario with maybe updated data, or Congress lets things go into effect and then we can look at the distribution of what happened there and say, "Hey, you did this, but guess what? You know, now here's the situation," and we can do more analysis on that.

I think, for my money, I feel like it's not a good use of our time until we know where Congress lands,

because we don't have anything new to say, other than to update these data, and here's what happens on the allotment methodology. And, you know, we can make all kinds of maps and stuff about those, and say what they say a little bit more.

I feel from the feedback that I have gotten from the Hill that they feel very satisfied with what we've done. We cannot provide them with the best political solution, that is everybody's a winner, but money doesn't allow that. So I don't think -- the fact that they haven't done a recommendation reflects badly on MACPAC.

CHAIR BELLA: Sheldon, and then Tom.

COMMISSIONER RETCHIN: Can I ask, do we ever hear from the safety net hospitals, America's Essential Hospitals, particular on this issue of global payment?

COMMISSIONER GORDON: [Off microphone.]

COMMISSIONER RETCHIN: Oh no, I mean about this. Yeah, I'm not saying that -- I know they're here.

[Laughter.]

CHAIR BELLA: This would be a good time to move to public comment.

[Laughter.]

COMMISSIONER RETCHIN: Here's my -- I'll just make my own plea, is that we include a strong statement in the report that encourages states, when they allocate, to look really closely at the California program, because now we have results, and I still say that the Parklands of the world, who employed physicians, right, or you certainly support physicians, that's the portal of entry that we're taking care of with this population. And the other allocations of DSH are going for admissions that largely come through the emergency room.

So as this goes, I think the portal of entry is going to go too. I still believe that. But maybe you could shift to public opinion. Maybe AEH doesn't -- isn't interested. I don't know.

CHAIR BELLA: That seems like a reasonable request. Good idea. Tom?

COMMISSIONER BARKER: I just wanted to reinforce the point that you made about a recommendation to Congress about whether or not it makes sense to rely on 1992 spending patterns. When I testified on DSH to the Energy and Commerce Committee in June I raised that in my testimony, and there did seem to be interest among members,

at least on the House side, in revisiting the formula.

But the problem that you run into, as you said, is it creates winners and losers, and the ideal political solution is when everyone is a winner, and that can't happen given that there is a fixed pot of dollars.

So I did think that there was interest, but whether it's politically achievable is an open question to me. But from my perspective, at least, that does not mean we should not continue to recommend it, because I personally think it's the right policy to change the allocation. It makes no sense to rely on what -- how -- what state spending patterns looked like 28 years ago.

COMMISSIONER MILLIGAN: Tom, I want to comment on this and your comment earlier, and going back to something I said earlier. I think MACPAC's work is impeccable here, and I think it is very evidence-based, very data-driven. I think it adds a lot of value. If, for whatever reason, the political will makes it very difficult to effectuate some of what we've recommended because of the winners and losers aspects of a lot of that, then so be it. The political body gets to decide that. You know, everybody is playing their role, in my view.

So I don't take it as any comment about MACPAC's work and work product, that recommendations may or may not be effectuated. I do think our role is to continue to be the nonpartisan, evidence-based source of truth about the data, and then the political bodies will do what they need to do.

So I do think continuing to kind of illustrate in some ways the historic distribution issues, because of where the clock was stopped back in '92, and how that continues to play out is relevant, as a lot of the rest of this is relevant. And I don't mean, and didn't mean, in any way, to disparage the quality of the work based on the recommendations. I think we are playing our role and I think the staff here is doing an impeccable job becoming and being the source of truth about all of this. So I wanted to say that.

CHAIR BELLA: Brian.

COMMISSIONER BURWELL: So I just have a clarifying question. I mean, I'm kind of with Anne. The recommendations that we made last year did rebase the 1992 allocations. Correct? Okay. So it's not like we've -- you know --

CHAIR BELLA: I don’t think we called it out so directly, in that way.

COMMISSIONER BURWELL: Okay. Okay.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah, and, I mean, I think Chuck's point about sort of taking the opportunity while we're talking about DSH to remind them of that seems fine. I mean, it seems like a good idea.

CHAIR BELLA: Do we have any comment from the public? Yes, thank you. We will have at least one today. Thank you.

PUBLIC COMMENT

* MS. GONTSCHAROW: Hi. Good afternoon. Zina Gontscharow with America's Essential Hospitals. I appreciate the opportunity to make these comments today, and we really appreciate the Commission's work on the DSH report. We know that it is not an easy lift, and we really appreciate the annual report.

America's Essential Hospitals has long advocated for any policies that better target DSH payments to safety net hospitals. Those are the hospitals in our communities that are serving the uninsured, Medicaid. We are the level one trauma centers. We are teaching the next generation of

physicians.

We recognize right now that there is a lot of uncertainty about whether or not the DSH reductions will actually go into effect. America's Essential Hospitals continues to advocate for at least, at minimum a delay of the reductions, and encourage the Commission to clearly communicate how devastating these cuts would be if they were to go into effect. And we look forward to any opportunity to work with MACPAC as you guys get ready for your March report.

So thank you.

MR. FINDER: Hi. Ben Finder with the American Hospital Association. There was a question on Slide 6 about what the underpayments, what's included in that. From the American Hospital Association annual survey data, that includes non-DSH supplemental payments, DSH payments, and base payments. Those are all included in the payments. So it is inclusive. The underpayments are inclusive of all of the Medicaid payments that come from states to the hospitals.

I just wanted to clarify. Thanks.

CHAIR BELLA: Thank you both. Any further

comments or questions from the Commission?

[No response.]

CHAIR BELLA: Ryan, anything else you need from us?

MR. GREENFIELD: I don't think so. Thanks.

CHAIR BELLA: Okay. Thank you very much.

We have finished today's sessions. We will start tomorrow with picking up on third-party liability with a focus on TRICARE. Following that we will move into a panel session on Medicaid and maternal health, and we will end the day talking about our work plan on maternal health.

We will start the public session at 9:00. So with that we are adjourned. Thank you all for joining us today.

* [Whereupon, at 3:37 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, November 1, 2019.]

PUBLIC MEETING

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

Friday, November 1, 2019
9:03 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
CHARLES MILLIGAN, JD, MPH, Vice Chair
THOMAS BARKER, JD
TRICIA BROOKS, 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
STACEY LAMPKIN, FSA, MAAA, MPA
SHELDON RETCHIN, MD, MSPH
WILLIAM SCANLON, PhD
PETER SZILAGYI, MD, MPH
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:03 a.m.]

CHAIR BELLA: All right. Let's go ahead and get started, please.

All right. We are going to start with picking up on some of our third-party liability work. Moira, it's all yours.

IMPROVING MEDICAID POLICIES RELATED TO THIRD-PARTY LIABILITY

* MS. FORBES: All right. Thank you, Melanie.

So this is part of our ongoing work to identify program efficiencies and opportunities to improve program management, and it builds on the work we did last year where we were looking at return on investment from various program integrity approaches. And that study has found that some states were -- actually, a lot of states were able to report positive return on investment from third-party liability. So it's an area that we investigated a little bit more.

So what I'm going to go over today is background on Medicaid third-party liability or TPL policies, specifically how Medicaid and TRICARE coordinate benefits

for the almost 900,000 people who are covered by both programs. I'll talk about some of the operational and policy gaps that limit coordination of benefits between those two programs, and some of the consequences this has for Medicaid. And then I'll talk about some of the potential steps that CMS could take to mitigate some of those gaps.

If there are federal policy options that the Commission wants to consider, including recommendations to the Congress or to the Secretary of Health and Human Services, we can conduct analysis of any specific options and bring back language at a future meeting.

Medicaid, of course, as a safety net program is a payer of last resort, which generally means that all other payers, any other sources of coverage, must pay claims under their policies before Medicaid pays. These are referred to as "third parties" because the individual covered person and Medicaid are the first and second parties.

There are different estimates of how many Medicaid enrollees have access to third-party coverage. The GAO estimated in 2012 that 56 million Medicaid

enrollees had access to public and private sources of health care coverage. This includes all of the persons who are dually eligible for Medicaid and Medicare. I think we heard yesterday that that's 12 million people right there. It's all the people who have access to employer-sponsored coverage, which people may have themselves, they may have through a spouse; or children may have that through their parents. People may have access through other public programs.

States report actual recoveries of TPL every quarter on the CMS-64. It's difficult to report cost avoidance, which are claims that Medicaid denies because of the responsibility of other payers, but that can be estimated. In 2011, the OIG estimated that Medicaid savings from coordination of benefits was $13.6 billion. That was 2011. Medicaid enrollment has obviously grown a lot since 2011. So, presumably, potential TPL cost avoidance is a lot greater.

Medicaid generally coordinates benefits with other insurers as a secondary payer, which means that if an insurer and Medicaid both provide coverage of a given benefit, the other payer is responsible for making payment,

and Medicaid is responsible only for the balance covered under Medicaid's payment rules.

States have two main sources of information on whether they may be a liable third party for a particular claim. The first is the enrollee. Medicaid beneficiaries themselves can provide information at enrollment or on an ongoing basis or at redetermination. And the second is data matches. States conduct matches with both insurance companies and with clearinghouses to identify sources of third-party coverage.

Generally, Medicare and other public programs can be liable third parties in addition to private insurers. Medicare is the big one, out of all the people in Medicaid who have secondary sources of coverage. Medicare is one program, and it is by far the largest source of third-party coverage.

There are a lot of processes and rules about how Medicare and Medicaid coordinate. We've talked about a lot of those here at Commission meetings -- the “lesser of” payment policies, Medicaid coverage of premiums and cost sharing.

Coordinating with all of the insurers in a

country that Medicaid has to coordinate with can be administrative challenging, and detailed policies like those that exist for Medicaid and Medicare don't exist for all of those other insurers. Medicare is the only one that there's a really clear process for all that coordination.

So to help reinforce Medicaid's status as the payer of last resort and reinforce that states need to make that effort, in the Deficit Reduction Act of 2005, Congress created a number of affirmative responsibilities for states relating to Medicaid TPL. They have to take affirmative measures to identify and collect TPL. They have to require state-licensed insurers -- so this is a state insurance law thing, not a Medicaid thing -- to conduct data matches with Medicaid. They have to accept claims for coordination for up to 3 years, and insurers in the state have to provide eligibility and coverage information to the state Medicaid agency so that Medicaid can coordinate with them.

The OIG, when it did its study in 2013, found that Medicaid TPL recoveries went way up after these requirements went into effect, and a lot of states started using contractor support to complete the required matches. They started working with TPL clearinghouses, which are

vendors that have agreements with a lot of insurers to help facilitate some of this information sharing.

Another complication for Medicaid, though, particularly since 2005, is now about two-thirds of beneficiaries are enrolled in managed care. So the state doesn't actually pay their claims. States have to decide if an enrollee has primary coverage through another insurer, do they exclude that person from enrolling in a managed care plan? If they are enrolled in managed care, is the managed care plan responsible for collecting TPL? If they're responsible for collecting TPL, how is that factored in the capitation rates? There is a whole sort of flowchart or decision tree of decisions that the state has to make around TPL, and because there's so many people in managed care, there's a whole set of responsibilities around that.

Medicaid and TRICARE. This is where I start calling Medicaid "Medicare," by the way. I do mean Medicaid.

TRICARE is the Department of Defense program for civilian health benefits for military personnel, retirees, and their dependents. So if your employer is the military,

TRICARE is your employer-sponsored health care.

Medicaid is secondary to TRICARE, and it covers cost sharing for TRICARE services, and it covers benefits that TRICARE doesn't cover, like home- and community-based services, adult dental in states that don't cover adult dental in Medicaid, things like that.

About 867,000 Medicaid enrollees, looking at the ACS data, have primary coverage through TRICARE. That's about 1.5 percent of Medicaid enrollees across the country. We don't have state-level estimates. It probably does vary a lot by state because the concentration of active-duty military and military retirees varies a lot by state, just based on where military bases are.

Medicaid is the source of wraparound coverage for a lot of children specifically in TRICARE. We estimate that about 220,000 children have both. That's about 10 percent of the kids of active-duty servicemembers.

In terms of coordination between the two programs, there's three main challenges. The Privacy Act of 1974 requires agencies to have like a formal public Federal Register-published memorandum of agreement in place in order to perform certain types of computerized matching

data programs.

The DoD and the Department of Health and Human Services do not have a data match agreement covering TRICARE and Medicaid, and they haven't had one since at least 2016. So there actually is no active program-level coordination between TRICARE and Medicaid right now and hasn't been for several years.

As I noted a few slides back, insurance companies in each state are required to share information on eligibility and coverage with Medicaid so that Medicaid can identify who has third-party coverage and for what. But TRICARE is not subject to that.

States determine Medicaid eligibility on a rolling basis. There's no open enrollment window. People come on to Medicaid all the time, so the Medicaid eligibility file changes every month. Even when there was an active data match between TRICARE and Medicaid, TRICARE, unlike other insurers, would only share information with states once a year. So instead of having information to be able to reject claims where Medicaid should be secondary, Medicaid may end up having to pay and chase until it learns about TRICARE coverage months down the road.

Another challenge states have recorded in coordinating benefits with TRICARE is it will only accept claims for one year. The DRA, again, requires state insurers to coordinate with Medicaid on claims for up to three years, but TRICARE has a one-year timely filing policy.

States may find claims that they paid but potentially should have been paid by TRICARE, but are for dates of service more than one year previous and were past that one-year window. So Medicaid ends up having to retain the liability for them.

It also makes the once-a-year data match an even bigger barrier because if a state learns about TRICARE coverage nine months after a claim was paid and that claim was for a service four months prior, then that's outside that one-year timely filing limit. So, again, Medicaid ends up liable for that.

Finally, TRICARE's policy is to coordinate benefits only with state Medicaid agencies, and it will not accept claims for Medicaid managed care organizations.

CMS stated in its guidance on the Deficit Reduction Act provisions that when TPL responsibilities are

delegated to an MCO, third-parties are required to the treat the MCO as if it's a state Medicaid agency. They have to provide information on the third-party eligibility and claims to identify people with third-party coverage. They have to adhere to the assignment of rights and so on, but again, TRICARE is not subject to any of those DRA requirements. And it doesn't voluntarily follow them.

So failure to effectively coordinate benefits could result in rate-setting errors, overpayment errors, and just generally complicate coordinate of benefits for those folks who have TRICARE coverage but are enrolled in managed care.

So, in sum, all three of these problems -- the lack of an active data sharing agreement, the one-year timely filing limit, and the failure to coordinate with Medicaid managed care plans -- all limit effective TPL collections for the estimated 900,000 people who have both Medicaid and TRICARE coverage.

This means claims costs that are the responsibility of TRICARE are being paid by state Medicaid programs. It's a cost shift from the Department of Defense to the Department of Health and Human Services and from the

federal government to the states.

We don't have an estimate of the amount of TRICARE TPL that's going uncollected by Medicaid, but again, it's 900,000 beneficiaries.

So that's the situation. If the Commission is interested in any follow-up work, it would be helpful to know if there are specific aspects you want to focus on because this would affect what kind of recommendations you can make. Some of these are policy issues; some of these are statutory issues, so if there's anything else you want to follow up on or if there's any more clarification on any of these issues I can provide.

I can turn it back over to you now.

CHAIR BELLA: Can I just ask a question and then we'll open it up? Even though it sounds like the data match agreement wasn't particularly sufficient because it was only once a year, why did it go away? Do you know?

MS. FORBES: Nope.

CHAIR BELLA: Thank you.

Questions? Comments from the Commissioners?

Martha, then Sheldon.

COMMISSIONER CARTER: Just a quick one. When you

talk about children, you think about CHIP. So is the situation the same for CHIP as for Medicaid? I just didn't look into that.

MS. FORBES: That is a good question. I believe so.

I mean, I looked at all of the data sharing agreements, and there are active data sharing agreements between TRICARE and Medicare and TRICARE and the federally facilitated exchange, but I didn't see one like with CMCS. So I assume it applies to CHIP as well.

EXECUTIVE DIRECTOR SCHWARTZ: But, Moira, it could be even bigger.

COMMISSIONER CARTER: Actually, can you not have CHIP and third-party coverage?

EXECUTIVE DIRECTOR SCHWARTZ: To be in CHIP, you have to be an uninsured child.

COMMISSIONER CARTER: That's right. I believe that it doesn't.

EXECUTIVE DIRECTOR SCHWARTZ: We talked with the CHIP directors about it because now CHIP is subject to TPL. In talking with CHIP directors, the source of that TPL would be mostly from like a settlement from a car accident

or something like that. The kids who are on CHIP can't have TRICARE.

MS. FORBES: Sorry. That's right. That's an eligibility issue.

COMMISSIONER CARTER: Thanks. Got it. Okay.

CHAIR BELLA: Sheldon?

COMMISSIONER RETCHIN: Moira, I like this, and I'll tell you why. I think MACPAC has built, in large part, a bipartisan respect for going after things that make Medicaid more efficient, and this falls in that category.

Let me ask you. Where I'm getting a little confused is with the MCOs, where does the responsibility lie there? Is it downstream with the MCOs or back up with the Medicaid programs? That's one question.

And because of the large issue here is with TRICARE, is this concentrated in a few states?

MS. FORBES: In terms of identifying and collecting TPL? Are you asking in Medicaid, generally, where does the responsibility lie?

COMMISSIONER RETCHIN: So when we say the loss of money, would that be because we would then -- the states would back it out of the premium? That is where I'm trying

to figure out where the lost revenue --

MS. FORBES: So some states have delegated responsibility for collecting TPL to the MCOs, and that responsibility is for all members with TPL.

TRICARE is one insurer for whom they are unable to do this.

COMMISSIONER RETCHIN: But if the MCOs did that or were able to do that, where would the revenue -- where would that --

MS. FORBES: That depends on the contract.

COMMISSIONER RETCHIN: I got it.

MS. FORBES: In some states, it goes back to the state, and that's accounted for in the rate setting. So that should be -- that's a rate-setting issue.

COMMISSIONER RETCHIN: Yeah. Okay.

MS. FORBES: The problem is that either it's in the rates or it's given back to the state, but if they can't coordinate with TRICARE, it's going uncollected.

COMMISSIONER RETCHIN: Yeah. That, I got. I just wasn't sure where it would flow.

MS. FORBES: Yeah.

COMMISSIONER RETCHIN: But then is it

concentrated in a few states, and is there an opportunity here to -- or are the states already collaborating together? I mean, TRICARE is not scattered to the winds. It is concentrated.

MS. FORBES: So there's sort of two things -- well, there's three things. There are states with a very -- I don't know how many -- I don't have the information on the overlap between TRICARE and Medicaid. I do know what states have a high proportion of TRICARE enrollees, and that's states like Alaska and Hawaii, a couple of southern states: North Carolina, South Carolina, Georgia.

COMMISSIONER RETCHIN: Right.

MS. FORBES: There are states that have a very high number of TRICARE enrollees. There are 900,000 in Texas. There are 800,000 in California. There are 750,000 in Virginia.

I also know that a couple of states of taken this up with their congressional delegations. For example, it was in Tennessee's 1115 waiver. A couple other states have raised it. Georgia has raised it.

COMMISSIONER RETCHIN: One thing that -- I don't want to dominate this, but one thing that I didn't see is

if the costs for actually data matching and some of the -- I think you did allude to the fact that some said it was just very expensive to do this or much less to get data sharing agreements. Is that an issue where collaboration between states would improve the efficiency of getting the data matching done?

MS. FORBES: Collaboration between states in what sense?

COMMISSIONER RETCHIN: Well, if they were to outsource it to another vendor.

MS. FORBES: In this case, it's data matching with TRICARE, which -- I don't know. Maybe we can follow up on it actually to see. That's certainly something we can follow up on.

CHAIR BELLA: So just to clarify, in our document, it does say it's $150 million cost shift. Is that something we should --

MS. FORBES: That was one estimate, and we don't have the underlying, how that was built up.

CHAIR BELLA: Okay. And, Sheldon, your point is if we're looking at $150 million, how much does it cost to go get that $150 million.

Darin, you wanted to make a clarifying comment, right?

COMMISSIONER GORDON: Yeah. It was your question about -- and Moira hit it -- where does the liability lie. You make an assumption on TPL collection when you do cap rate development. So the assumption is that they will get it.

Now, Moira hit this as well. We ran into the issue, while you do have that implied amount in there, whether or not you identify through other matches, you the state, whether or not you should say at some point, you know, plans, you've had the opportunity to find this --

COMMISSIONER RETCHIN: We baked it in.

COMMISSIONER GORDON: -- but now we have identified stuff you have not gone back and built third-party liability, and so then the state picks up after a certain point.

To your point, it is a complicated situation because we had to come into an agreement of how much is sufficient time to allow the plans to go and get this, and at some point, where does the state need to step in and pick that up?

The only other comment I will make, which wasn't something Sheldon brought up and made me think about it, though, we talked about the cost shift to states in the Medicaid program, but also, it's a provider issue as well, as they're getting Medicaid reimbursements where they could get TRICARE reimbursement if that window was widened.

CHAIR BELLA: This is a popular topic. We have Bill, Kit, Tricia, Kisha, Toby, Chuck, Tom. Just so you all know, you're on the list, but, Bill?

COMMISSIONER SCANLON: Well, I mean, I guess my comment relates to what Shelton and Darin have just been talking about.

The issue in my mind was, What's the potential here? The MCO is not, in some respects, being sort of a problem, but sort of being sort of an opportunity. Isn't that in their interest to pursue these third-party liabilities?

But what Darin said, if you're observing them too closely and you're taking the money back after they've captured it, then that really undermines the incentive, so to speak. I mean, there's that.

I guess the question is how much variation there

is across states and whether there are opportunities where people have sort of done a better job -- on the part of MCOs have done a better job in terms of being able to pursue this and is there something to learn there.

The other question I have in my mind is kind of on the TRICARE side. Who is going to pay if you do get TRICARE to pay? What budget is this coming out of, so to speak? What is their incentive to cooperate? TRICARE is a public program, but it's also sort of administered privately, and what are the terms of that private administration? Is it in their interest to be cooperative or not cooperative?

CHAIR BELLA: Kit.

COMMISSIONER GORTON: So I want to follow up on what Bill was just talking about, but first, thank you for doing this. I mean, I got to this place in the packet and I was like, wow, Christmas came early. This is really wonderful.

[Laughter.]

COMMISSIONER GORTON: Well, people know I've been pushing for four years now, you know, let's find program efficiency. So this is good stuff.

As Bill said, the TRICARE program is also outsourced, so there's not only Medicaid capitation, where plans are or are not being capitated for these services, there's TRICARE capitation, where plans are being capitated for these services. And to the extent that they can cost shift that to Medicaid, to Bill's point, it's in their interests to sort of not have this agreement and take advantage of the opportunity.

I personally don't think this should be optional for the Department of Defense, and so -- and I think it rises to a level of importance. I mean, that $150 million estimate is per year, right? So over a 10-year CBO score we're -- I mean, we're talking about real money. And so -- and if what's happening is a big chunk of that money is going to TRICARE MCOs, and states are picking up the tab, that's not only an unfair and inefficient burden on the states, it's -- you know, it just sort of gets into all of these arbitrage-y kind of things.

So my view would be important work. I would like to see us moving towards, sometime next year, maybe June, getting a place where we can sort of be descriptive about all of the moving parts, and then, potentially, if we've

learned enough and we feel comfortable enough about some of these numbers that we might get to a place where we could recommend that either the Secretaries get together and do this because they should, or that Congress just says, no, this is not optional. TRICARE needs to do this, as does every other federally funded health care program. You've got to coordinate benefits with Medicaid. If we want to do it in an administratively simplified way, and some sort of centralized way, I get the many-to-many issue. But that's an ops question. That's not a policy question.

CHAIR BELLA: Moira, did you want to comment on that?

MS. FORBES: Just to clarify, TRICARE is administered by private insurance companies on an administrative-services-only contract. DoD holds the risk.

COMMISSIONER GORTON: Yes. I'm sorry. I was imprecise about that. But it's the vendors who the actual TPL would have to -- the data-sharing and that sort of thing may have to happen at the vendor level.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: So not to take us off topic from TRICARE, but I think there are other issues in third-

party liability that affect children -- and saw this coming, maybe. You know, the statute still does not require states to do coordination in regard to children's pediatric preventive services, including all of the EPSDT services. And it gives them the option to do that if they determine it's cost effective, and I am all for cost effectiveness.

But it should also not adversely affect access to care, and I don't think we know enough about the extent to which it would impact our access to care, and I think that it would be important for CMS to give some additional guidance and do additional data collection to really understand the impact on access.

And just one more quickie, and that is that, in particular, children who are subject to child support enforcement orders, you know, are probably even more at risk than other kids on Medicaid.

CHAIR BELLA: Thank you. Kisha.

COMMISSIONER DAVIS: Thank you, Moira. This is really great. I just had a question to better understand these beneficiaries. Why is it that they are needing TRICARE and Medicaid? You know, what about them -- is it

that they are requiring both? Is it because they are mostly retired, or do they have extra health benefits? Are there duals? Do we know anything more about this population?

MS. FORBES: So we have some very rough breakdowns from the survey data. They can qualify through any of the Medicaid pathways. So it includes people who are qualifying on the basis of income and household size. It includes children who are qualifying on the basis of disability. It includes adults who are qualifying on the basis of disability. So they are coming in through all of the Medicaid pathways, but it includes -- it includes a fair number of children who are disabled and receiving -- who are getting a lot of wraparound benefits that Medicaid provides, that TRICARE does not provide.

COMMISSIONER DAVIS: So it would be really -- I think it would be nice to know that. I mean, is their income not adequate, or, you know, is there something about these military service folks where their military service benefit isn't adequate in some way? And so I think it would be helpful to know a little bit more about that.

CHAIR BELLA: Toby, then Chuck, then Tom.

COMMISSIONER DOUGLAS: So I just want to make sure I understand. Other than administrative time on TRICARE, and financial shift back to TRICARE, what is the impact on the Department of Defense if we recommend to reinstitute the once-a-year data matches, the three-year period, as well as allowing delegation to the MCOs to do the coordination? What would be the impact?

MS. FORBES: Well, I think we can eliminate recommendations that affect only Title XIX, so I think we would have to figure out how to make a recommendation about --

COMMISSIONER DOUGLAS: Okay. That's fair --

MS. FORBES: -- I mean, for one thing.

COMMISSIONER DOUGLAS: But maybe let me just ask the question. Forget about the recommendations.

MS. FORBES: But yes. I mean --

COMMISSIONER DOUGLAS: What is the impact?

MS. FORBES: And we have started talking to the CBO, to try and get better estimates, and we're sort of giving the heads up.

COMMISSIONER DOUGLAS: Yeah.

MS. FORBES: But, no. I mean, I think your

question is -- yes, I mean --

COMMISSIONER DOUGLAS: I didn't mean to mean it in a --

MS. FORBES: No. I think you're right. It would be --

COMMISSIONER DOUGLAS: We're cutting to --

MS. FORBES: -- to do the --

COMMISSIONER DOUGLAS: It seems like this is really a question of TRICARE, are they going to step up -- or not TRICARE -- Department of Defense to do the administrative work with the MCOs, and knowing that it will then shift money back to them, that they have to fund.

MS. FORBES: I don't know what -- I haven't talked to TRICARE. I don't know what -- I have read their policy documents. I have read the TRICARE reimbursement manual. I have read their annual reports. I don't know what is behind their decisions to do the policies this way. I only see what their policies are. So I can't really explain their rationale for this.

COMMISSIONER DOUGLAS: Okay.

CHAIR BELLA: Chuck?

COMMISSIONER MILLIGAN: Moira, the $150 million

estimate, is that the state match part, from even -- we don't know?

MS. FORBES: No.

COMMISSIONER MILLIGAN: Okay. I just want to tie Kit's and Toby's questions. So if there was a recommendation about Medicaid TPL policy that would have an impact on TRICARE, it would be a net cost to the federal government, not a net savings to the federal government. Right?

MS. FORBES: Presumably.

COMMISSIONER MILLIGAN: Okay. I just -- I think the part that I would like to contribute is I think we should continue the TPL-related work. I wouldn't limit it to TRICARE. I do think there are some other things that are worth keeping an eye on. I think one of the issues that we've talked about in previous meetings, primarily in the DSH discussion but it's related to this TPL discussion, is the increase in high-deductible plans. And I think Medicaid is stepping up and paying first, where people have high-deductible plans, because a lot of the beneficiaries don't have the resources to pay their deductible. I think we have to keep an eye on that.

The other one I would want to keep an eye on is actually the policy that -- you mentioned kind of tort issues -- car accidents, medical malpractice, that kind of stuff. Medicaid is supposed to get recovery for whatever the insurance company paid related to the tort, but a lot of times Medicaid doesn't recover the full amount because judges and others don't want to create a disincentive for individuals to pursue their claims in court.

I think there's an area around TPL, as a subject matter of which TRICARE fits within, that I think we could advance, in terms of our stewardship on the Medicaid side.

CHAIR BELLA: Tom?

COMMISSIONER BARKER: I was actually going to make the point that Chuck just made, about tort liability and also worker's comp. In 2007, Medicare really tightened up the Medicare secondary payer rules, and they addressed worker's comp and torts. I don't know if that would work in Medicaid -- maybe it wouldn't -- but that's something we could look at. So I agree with Chuck's point.

MS. FORBES: And, Chuck, in terms of the net cost to the federal government, I mean, again, when we talked to the CBO, if the recommendation is limited to Title XIX, I

mean, one of the questions I guess we'll ask is, when we're estimating the cost of this, is the cost limited to the recommendation? You know, when we're looking at that.

COMMISSIONER MILLIGAN: My premise was when you described a cost shift in the slides it was a cost shift to Medicaid from DoD by being unable to go get the TRICARE recovery. And so if we were to recommend something that would mitigate that cost shift, presumably it would save Medicaid money, meaning states, partly, and increase the DoD obligation. So it would be a net-net increase to the federal government. That was my assumption.

MS. FORBES: Yes.

CHAIR BELLA: Kit?

COMMISSIONER GORTON: But I think we should push on that and prove it, because if you're looking at the level of claims I think that might be true. But if capitation is happening -- and I understand that it's a TPA arrangement -- but if there are risk arrangements that are going on, if there are other things, I would just like to prove to ourselves that we're not paying two insurers, prospectively, to serve a single member. Right? I just want to make sure that TRICARE is not overpaying and

Medicaid is not overpaying.

COMMISSIONER MILLIGAN: My last comment, and I know we need to move on. I agree that in terms of just the integrity of the program we should keep an eye on it and keep working on TRICARE, and sort of advance this work. I think, though, that it would be prudent to not limit it to the TRICARE element of TPL --

COMMISSIONER GORTON: Absolutely.

COMMISSIONER MILLIGAN: -- in terms of that broader fiscal stewardship piece.

CHAIR BELLA: So I -- that's exactly where I think we should be thinking about. I mean, I guess I have a couple of reactions. One is just kind of, are you kidding me that other federal agencies wouldn't have something in place, right? Second is: there's all this attention to like program integrity for beneficiaries who have an extra month or two on the program, who shouldn't be on the program, and we're talking about sort of an organized cost shift from other payers.

And so I guess I just want to throw in, when we think about stewardship, in general, and we can think about -- what I don't have a good understanding of is, is DoD,

proportionally, is it tort? Is it other insurers? Is it DoD? Is it VA? Because, by the way, I mean, VA -- you want to make your head spin, talk about people that have Medicaid, Medicare, and VA coverage.

And so I just want us to think about -- I'm not saying that we should throw -- we're not going to be able to chase it all down, but as we think about what we want to focus on, let's have some understanding of the proportionate value in terms of where the cost shifts are happening at any of these different points.

Any other comments from the Commission?

So you hear a lot of interest in continuing, I think, exploring a recommendation. It doesn't sound like we're -- we're not concrete on what that recommendation is right now, but certainly strong interest from the Commission to continue looking at all of these areas. So you have teed up something with TRICARE that obviously has interested us quite a bit, so thank you.

We'll turn to the public now for any public comment.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: I thought we had a public comment, but it was just someone getting up to offer the seat.

All right. No comment from the public? All right. Anything else from any Commissioners?

[No response.]

CHAIR BELLA: Great. Thank you.

[Recess.]

CHAIR BELLA: All right. We are going to reconvene. Welcome.

We are excited to go deeply into issues on Medicaid and maternal health and welcome our panelists. Thank you for being here. Martha, please take it away.

PANEL: MEDICAID AND MATERNAL HEALTH

* MS. HEBERLEIN: Thank you, Melanie.

There has been a lot of news lately about the maternal health crisis in this country, and although most births occur without adverse outcomes, pregnancy-related mortality and morbidity have been on the rise, with approximately 700 women dying annually as a result of pregnancy or related complications.

There's also significant racial and ethnic disparities, especially with black and American Indian and

Alaska Natives having higher pregnancy-related mortality.

So while the maternal health crisis is not solely a Medicaid matter, there is an opportunity to address the poor outcomes for many women through improvements in the Medicaid program. Medicaid has long played an important role in providing maternity-related services for pregnant women, financing almost half of all births in 2017.

So to advance the discussion on Medicaid's role in maternal health, we're kicking off our work on this topic with a panel of experts to discuss federal Medicaid initiatives to improve maternal health.

Two recent grant opportunities from the Center for Medicare & Medicaid Innovation, or CMMI, have targeted maternal health. The Strong Start for Mothers and Newborns Initiative sought to improve maternal and infant outcomes for pregnant women in Medicaid and CHIP, with a focus on enhanced prenatal care.

The forthcoming Maternal Opioid Misuse, or MOM, model seeks to address the opioid epidemic by supporting coordination of clinical care and other services critical for well-being and recovery.

The current administration has also focused on

improving access to maternal health care in rural communities, and today's panel will discuss these programs.

So, first, we will hear from Ian Hill, who will discuss the Strong Start Initiative and the results of the evaluation. He is a senior fellow at the Urban Institute with over 35 years of experience directing evaluation and technical assistance projects on health programs for disadvantaged individuals and families. Mr. Hill is a nationally recognized maternal and child health expert and directed the Strong Start for Mothers and Newborns Evaluation.

Then we will turn to Dr. Cara James. She is the director of the Office of Minority Health at CMS and co-chair of the CMS Rural Health Council. She is a nationally recognized expert in health disparities, health equity, and improving health outcomes for vulnerable populations. As the director of the Office of Minority Health, Dr. James leads CMS' efforts to meet the needs of minority and underserved populations. She will discuss the MOM model and the administration's focus on rural health.

Each of our panelists will give a brief presentation, and then as is our custom, we will use the

remainder of the session for a conversation between Commissioners and the panelists. And following this session, I will give you a short overview of our work plan, and then you will have a chance to provide feedback on what you hear from the panel as well as the work plan that I will propose for this year.

So, with that, Ian.

* MR. HILL: Good morning, everyone. Can you hear me okay?

It's a real pleasure to be here. Thank you for inviting me. I am honored to speak with you all about the Strong Start for Mothers and Newborns Evaluation and our evaluation of it at the Urban Institute. As Martha said, I'm a senior fellow in the Health Policy Center at Urban, and I was the project director for this five-year evaluation of Strong Start, which ended just over a year ago. I'm speaking on behalf, though, of a large number of colleagues that contributed mightily to this work, not only at the Urban Institute but also some of our partners at the American Institutes of Research, Health Management Associates, and Briljent. So I want to acknowledge that.

I also want to acknowledge our funders, CMMI, for

funding not only the Strong Start for Mothers and Newborns Initiative, but also our evaluation. And, finally, Caitlin Cross-Barnet, who is our contract officer of record, our project officer, who was an incredibly passionate and driving force and really contributed well to the study.

In the time that I have with you, I'm going to provide some background about Strong Start. I'm going to discuss our evaluation methods. Then I'll summarize the top-line findings from our work, primarily focusing on the impact that Strong Start had on birth outcomes and costs. And then I'll finish with some remarks about the implications of these findings for Medicaid and CHIP. I'll touch on those briefly, but we can certainly engage on those more in the Q&A when I'm done.

So what was Strong Start for Mothers and Newborns? It was a federal initiative designed to support the delivery of enhanced alternative prenatal care for pregnant women on Medicaid and CHIP. We all know, and as Martha summarized, the rates of preterm birth and low birth weight in this country are very high, and especially high among women on Medicaid. And research has consistently shown that infants born preterm have higher mortality and

may face and endure a lifetime of developmental and health problems compared to infants who are born at term. On top of that, the U.S. spends more money on maternal care than any other developed nation, and yet we experience these poor outcomes.

So, with that in mind, the Strong Start Initiative set out to achieve the following goals: lower rates of preterm birth, which is defined as delivery prior to 37 weeks' gestation; lower rates of babies born at low birth weight, which is defined as birth weight lower than 2,500 grams; and reduce the cost of care by reducing the incidence of high-cost poor outcomes.

There were three models of enhanced care that Strong Start supported. The first one was the birth center model, which embodies the more time-intensive, holistic midwifery model of care. It was augmented under Strong Start by the addition of peer counselors who provided additional support and referrals.

The second model was group prenatal care, which provides prenatal care in a group setting of women, about eight to ten women at a time, with a heavy emphasis on education and building supportive peer relationships among

the women in the group. Most of the models used the CenteringPregnancy model, if that's something that you might be familiar with.

The third model was the maternity care home, and all of you can think of this as a prenatal care version of a patient-centered medical home where all prenatal care is centralized in one clinical setting. And what Strong Start models did was typically add a care management or care coordination component to that clinical model. And in some cases, they added other enhanced services like nutritional counseling.

Strong Start made awards to 27 organizations operating over 200 provider sites in 32 states, Washington, D.C., and Puerto Rico. It operated from 2013 to 2017, so it was a large, large initiative that served nearly 46,000 women over the course of the four years.

From our data we know that these women displayed a wide range of medical risks, including things like pre-pregnancy diabetes and hypertension, overweight and obesity. We also know that they faced numerous psychosocial risk factors, including unstable housing, unemployment, depression and anxiety, food insecurity,

barriers to care, and whatnot.

So that's the Strong Start model. Let me talk a little bit about the evaluation that we undertook.

Urban was charged with answering several research questions, including: How did Strong Start prenatal care differ from typical prenatal care under Medicaid? What were the characteristics of Strong Start participants? What was the impact of Strong Start on key maternal and infant outcomes like preterm birth, low birth weight, and costs and C-sections? And what features of Strong Start help explain some of the variation that we saw in our outcomes?

We took a mixed methods approach in our work. There was a very large case study component to really learn about what Strong Start was doing. Over the course of four years of data gathered, we conducted about 750 interviews with almost 1,000 key informants. We also did 130 focus groups with about 950 women in the program.

We had a large participant level process evaluation where we gathered data on the 46,000 Strong Start enrollees, and we gathered data at four points in each woman's pregnancy: intake, third trimester,

postpartum, and then on exit from the program, which was more of a medical record review.

And then, finally, for our impact analysis we used linked birth certificate and Medicaid eligibility and claims data for women in Strong Start and women in our comparison groups receiving typical care.

So that was the evaluation approach. Let me hit on the top-line findings for all of you. I could easily spend two or three hours walking you through the massive reports that we produced, especially on the case studies, participant, data, and whatnot. But I'm going to hone in on the impact findings because I think that's the bottom line that you're perhaps most interested in today that was based on our analysis of linked Medicaid and birth certificate data.

Let me talk just briefly about the data sources. We received birth certificates from 12 states and the District of Columbia for the births in 2014, '15, and '16. We obtained Medicaid eligibility data from those same 12 states and D.C. for the same three years. And we received Medicaid claims and encounter data from eight of those 12 states plus D.C. for two years, 2014 and '15, because as

you all know, the data lags can be considerable in Medicaid costs, and so the 2016 cost data would have taken us past the end of our contract.

By linking those sources, we were able to create analytical files for all Medicaid-covered births among Strong Start participants as well as women in the comparison group.

For those researchers among you, our analytical approach, we used propensity score reweighting to develop estimates for the comparison groups of women receiving typical care. We did comparison groups in each county where Strong Start was operating, so it was a large undertaking. And we used data like demographic characteristics, behavioral risk factors, medical risk factors, hospital characteristics, Medicaid eligibility categories, and diagnostic risk factors to build these matched groups. The key point of this is that the comparison groups were risk matched for each of the models.

We estimated the impacts of Strong Start at the model level, meaning all birth centers, all group prenatal care, and all maternity care homes, and also at the awardee level, and when the samples were large enough, at the site

level.

You've heard me say "typical prenatal care" a few times, and I want to just spend ten seconds on that. The vast majority of women on Medicaid receive their prenatal care currently in private, solo, or group physician practices, at FQHCs, at hospital outpatient departments, and the typical care can be characterized as medical in nature, what many people consider as overly interventionist in terms of things like C-sections, spends insufficient time on health education and psychosocial support, and often lacks continuity in that women will see multiple providers over the course of their pregnancies. And so Strong Start really set out to change those dynamics.

So what did we find? Let me give you the punchlines first, and then I'll dive into a little more detail.

For the maternity care home model, we found few significant effects, really no significant effects on birth outcomes, cost, or utilization.

For group prenatal care, we also found few significant effects on birth outcomes, though we did see some reduction in cost during the prenatal period.

And for birth centers -- this is where the big news is -- we found numerous significant and large effects on birth outcomes, cost, and utilization. Specifically with regard to outcomes, we found higher gestational age babies for the women who were served by birth centers, lower rates of preterm birth, lower by 25 percent. We saw higher birth weight babies and, along with that, lower rates of low birth weight babies, 20 percent lower. We saw lower rates of C-sections, 40 percent lower than women in typical care, as well as higher rates of vaginal birth after C-section.

So, basically, every important measure that we were interested in following we saw large and significant effects.

With regard to costs, we saw lower expenses during the delivery period for women served in birth centers; lower expenses during the year following birth with mother and infant dyads, about 16 percent lower, or $2,000 per pair; lower infant ED use; lower infant hospitalization; and so we assume that those lower costs that we see for Strong Start birth center care driven by lower C-section rates, shorter birth facility stays, and

added savings from infant utilization going down.

So what are the implications of these findings for Medicaid and CHIP? As Martha said, Medicaid pays for nearly half of all births in the country, so the implications of these findings are potentially huge. Simply put, if more women accessed care in birth centers for their maternity care, they'd likely experience better pregnancy outcomes. Their infants would start their lives healthier, and Medicaid would reap significant savings.

The problem, unfortunately, as we probably all know, is that Medicaid -- that women giving birth in birth centers make up a tiny fraction of all births in Medicaid. We know that state regulations can limit the supply of birth centers and midwives that can practice in the states. We know that scope-of-practice laws and licensure policies can make it difficult for birth centers and midwives to practice in some states. We know that Medicaid reimbursement is low for birth centers and midwives compared to OB/GYNs in hospitals. And we know that Medicaid MCOs often struggle to contract or birth centers and midwives with MCOs struggle to reach suitable contracts.

Still, we think that the Strong Start Evaluation shows that it is possible to move the needle on preterm birth; that the midwifery model, which, again, is more holistic and time-intensive, that involves 30-minute prenatal visits, not the five to ten minutes that you might get from an OB; that focus on education, on things like nutrition, exercise, childbirth preparation, pregnancy spacing, breastfeeding, infant care, self-care seem to be the driving forces that really change the experience for women.

We also speculate that the characteristics of this model can be implemented by any provider in any setting -- right? -- if you choose to emphasize education and time.

So moving forward, I would just say that comprehensive prenatal care that addresses not only medical factors but social determinants of health like that practiced in birth centers will be needed to improve birth outcomes on a large scale.

And I guess finally I would say that we focused on the immediate birth outcomes and costs over the first year, but I think it's important to realize that the long-

term effects that preterm births have on infants, the rates we were talking about a moment ago about maternal mortality and morbidity that occur from repeat C-sections really have the potential to benefit, to offer health benefits and lower costs over a much longer period of time.

So thank you. I've gone over by a couple minutes. I apologize, but I am happy to answer your questions when we get to that point. Thank you.

* DR. JAMES: Okay. Good morning again. My name is Cara James and I am pleased to be here today to talk about what we're doing within the space of rural health and maternal health at CMS and in the Department. And I think, as Martha mentioned, the statistics on maternal health and how much attention is being paid to it, I think we all can see that there is probably equally, if not more attention, being focused on rural health and the sort of rural-maternal health intersection is pretty unique in some of the challenges that we face there.

So a couple of years ago we started the CMS Rural Health Council, and as a result of a number of listening sessions that we did, we kicked off our Rethinking Rural Health Initiative last year with the launch of our CMS

Rural Health Strategy. We did these listening sessions in rural communities like Pocatello, Idaho, and Rifle, Colorado, and talked to beneficiaries as well as a number of stakeholders, and came up with five objectives to focus on rural health.

The first is what we call applying a rural lens to CMS programs and policies. So that's thinking about the implications of what that may mean for rural access, rural financing, rural data collection and quality, and rural provider participation, before we put out policies. So I like to say that if we're doing it right I'll get fewer angry letters from the National Rural Health Association, in terms of the complaints that they have about what we're doing.

And I will say that we have been successful in that, that we have fewer letters coming in, and the CEO of the National Rural Health Association said, in May, he doesn't have many things on his list. So I think that's a start, but really thinking about those implications on the front end.

The second objective is to improve access to care through provider engagement and support. And so we think

about a lot of the technical assistance that we're providing to rural providers to be able to participate in APMs and quality payment programs and other ways in which they can report on those quality metrics, and to help reduce burden in terms of their ability to focus on the patients.

The third is advancing telehealth and telemedicine. We have done a lot of work in that space to try and improve access to care and support that. We have already heard some of the challenges in terms of state licensing and issues related to that, but within that space we are trying to push the boundaries where we can to address some of the particular challenges related to things like store-and-forward as well as the ability to have telehealth outside of a clinical setting, which is one of the requirements in Medicare.

And then the fourth is to empower patients in rural communities to make decision about their health care. Our health care system is challenging and difficult to navigate, and particularly for some of those rural beneficiaries who are dealing with additional burdens, transportation and other things, to try and navigate

through the health care system.

And then, finally, we can't do this work alone, so we want to leverage our partnerships. We work really closely with the federal Office of Rural Health Policy and others to achieve the goals of our strategy.

So since launching the strategy, we have engaged in a number of activities. We have technical assistance that's been provided for our quality payment programs, and, as a result, we have seen that over 90 percent of eligible rural providers have participated in the program. They have received overwhelmingly sort of positive bonuses related to that participation and have been able to report much more than the minimum of what was required in terms of that.

As I mentioned, in the space of telehealth we have added additional codes to expand access to telehealth services in Medicare as well as providing virtual communication codes for in-person services over the phone, telephonic services over the phone for beneficiaries to receive care from providers, as well as to do store-and-forward to allow providers outside of the space to see that, so it doesn't have to be live.

We also have been working and just finalized the hospital wage index to try and equalize that in terms of redistributing some of the benefits to help support those low-wage areas which tend to be more likely to be rural. And then, because we know workforce is so important, we also have allowed for the changes to allow for critical access hospitals with direct GME and IME, so that hospitals can count those FTEs in their work.

And then, of course, we have the opioid strategy and the overlap between opioids, maternal health, and some of the outcomes that we're seeing. So we've been focusing on providing state flexibilities through 1115 waivers, putting in some of the restrictions that we have, and also implementing provisions of the SUPPORT Act to increase access to opioid treatment programs and other areas.

And then also looking at our data and to see where we have opioid prescribing, looking at a rural-urban lens as well as looking at the states within the Medicaid program to see what's happening there.

And then I would say we also have the intersection of the work within minority health and rural health. And so when you look within rural communities, we

did some work with the CDC Office of Minority Health and Health Equity as part of the rural health series that was part of the morbidity and mortality weekly review, and looked at some of the outcomes for rural minorities.

And we find that we have worse health outcomes, particularly for African Americans who report their health is fair or poor, at about 30 percent, similarly for American Indians and Alaska Natives living in rural areas, compared to about 19 percent for non-Hispanic whites. And when we think about income and some of the relationship to Medicaid, we also see that rural African Americans, in particular, and American Indians and Alaska Natives are significantly more likely to be living in poverty in rural areas. And the geographic distribution, we know that where you live matters, and we see that, overwhelmingly, 94 percent of rural African Americans are in the South.

So couple that with a lot of the challenges we see in terms of some of the other statistics, to add to the conversation, we've seen over 155 rural hospitals that have closed since 2004. We have about 40 percent of rural hospitals that are operating at negative margins, and some of the work that we've seen shows that they are

disproportionately in some of those states that have not expanded Medicaid, and also disproportionately impacting some of the communities of color. So thinking about what that means.

And then Ian mentioned the social determinants of health, and that's another space that we have been involved in. We have finalized, for the first time -- we don't have a lot of standardized data around the social determinants of health. There are a number of frameworks out there that people are using, such as the one with the Accountable Health Communities model or the National Academy of Medicine Social Risk Factors. We have the PRAPARE tool, Health Leads, and there are innumerable number of private tools that people are using to measure social determinants of health that we are not measuring them in the same way.

So as part of an effort to try and help with that, we finalized, in our post-acute are rules, that we will begin collection of some of the social determinants of health in our patient assessment tools. And the window of opportunity for that was alignment across the assessment tools as a result of the IMPACT Act. So those data will begin coming in and we'll be able to look at the

relationship to things like transportation, social isolation, and other issues related to quality outcomes and cost in those areas. And we will continue to look at additional areas in which we can begin collecting some of that information to help standardize that.

So when we look at the space of Medicare and Medicaid, and at maternal health in particular, this is an area that we held a forum in June, in collaboration with ACOG, AAFP, CDC, HRSA, and others, to really think about the issues associated with access to maternal health services in rural communities.

So as I noted the rural hospital closures that we have seen, there are a number of other rural hospitals that have just closed the OB departments, and we now know that about half of the communities in rural counties have no access to hospital services for OB. Women in rural communities are having to drive numerous hours to get to care, to not only deliver but what that means for prenatal, postpartum, interconception, and all the other services that are needed.

So this forum we held, we looked at that, and we are continuing to develop work out of that. We will have a

portfolio of work that's going to be rolling out over the course of next year. And we are working, as well, because at the Department some of you may have participated, that there have been listening sessions that the Secretary and other leaders held, to get input on what the Department should do with regards to maternal health. So there are focus areas across the Department looking at rural health, maternal health, as well as social determinants of health, all trying to develop action plans for how we can address a number of these issues, and looking at the intersection of them.

Ian talked about some of the models that we have, in terms of the Strong Start, but we also have the MOM model, the Maternal Opioid Misuse model, that is rolled out. That was announced in April of this year. The sort of, if you will, companion model is the InCK model, the Integrated Care for Kids model that came out in May, working both with states, Medicaid agencies for the MOM model and for state Medicaid agencies or community lead organizations in terms of the InCK model, to look at that access to integrated care and coordination of care around a number of issues for maternal health as well as behavioral

health, thinking about opioid misuse, neonatal abstinence syndrome, and the impacts of that.

So the InCK model will work for kids from birth basically through 21 years. The MOM model looking at a number of services, both prenatal, perinatal, as well as postpartum.

And from the rural perspective again, some of you may have heard that we are working on a rural-specific model that will allow communities to adjust and adapt to payments and structures that address their specific needs within their rural communities. And so that will be one also with collaboration focusing on a number of areas. We expect that maternal health may be part of that conversation as well.

So stay tuned. A lot more to come. And I know that was like whirlwind tour, but I look forward to questions.

CHAIR BELLA: Thank you very much. We really appreciate you both being here.

Martha, would you like to kick us off?

COMMISSIONER CARTER: I would. Thank you so much. I have to disclose I'm a nurse midwife, and during

the time of the Strong Start study the FQHC where I was CEO was a subgrantee. So we contributed a tiny amount of data, rural by center. So I have some knowledge of that arm.

So I have a couple of questions for you, Ian. Looking across the three arms of Strong Start, there were similarities in that all three focused on additional case or care management, but the birth center model was more peer support. So I wondered if you could tease out of your data whether that made more of a difference than sort of typical case management than, you know, attempting to connect women to resources.

And the second question, which is similar, is the birth center model. It wasn't really as much about birth centers as it was about the midwifery model, I believe. And talk more about that. I think that was the only model that was exclusive midwives. Is that right?

MR. HILL: That's true.

COMMISSIONER CARTER: The other models were -- or the other arms, if you will, were mixed provider types?

MR. HILL: That's true.

COMMISSIONER CARTER: And so, again, could you pull out of your qualitative, or quantitative, data, the

effects of the peer support and the midwifery model? And if you can't, that's okay. I'm just curious what you can comment about that.

MR. HILL: Sure. Sure. So the midwifery model, as we observed, and as I mentioned and as you referred to, time is very important in terms of allowing for not only a clinical visit but also entertaining questions and building a relationship. I would say that one of the key ingredients across the board, all three models, at different levels, was the development of this relationship-based care -- midwives and peer counselors in the birth center model, the facilitator of the group session but also the other peer women in the group for the group prenatal care model, and the care coordinator for the maternity care home model.

We do not think that we can attribute the improved outcomes in the birth center to the peer counselor. The addition of that piece, that part of the intervention, was fairly light touch, about four contacts per pregnancy. Usually occurred just after a visit with the midwife, but usually in person. And yet from focus groups we heard women sing the praises of these peer

counselors very highly, that it was, even as established as a relationship might be with the midwife, the peer was someone that women felt they could open up to even more, and maybe disclose things about domestic partner violence or substance use that could then cycle back to the midwife. So I think it was a really important component that women appreciated.

Does that answer your second question, or the --

COMMISSIONER CARTER: The first one, I think.

MR. HILL: Okay.

COMMISSIONER CARTER: And the second one was about -- I forget what order I asked them, frankly, but the other one was about midwifery care versus mixed provider types.

MR. HILL: Right. Right. So midwives were involved. Often they were the facilitator of the group prenatal care sessions, not exclusively but it was mixed. They are certainly, at FQHCs, involved with the maternity care home model, but typically more physician-based practice there.

I guess the -- some of the differences were that in a birth center the midwife was continuous for the women,

throughout their pregnancies, whereas even if a midwife was involved in the maternity care home model there was no guarantee that a woman would see the same provider over the course of the pregnancy, so that was a weakness of the maternity care home model.

I think that the whole orientation and approach by the midwives related to extra time, extra focus on education, extra focus on psychosocial support, engaging women on those issues that go beyond a medical issue, were the key ingredients and certainly a focus of all three models, to some extent, but much less in the maternity care home. I hope that helps.

CHAIR BELLA: Peter.

COMMISSIONER SZILAGYI: Yeah, thank you both. This is a really, really important area, and very exciting to hear some of these results.

Also, on disclosure, I was co-director in Rochester, New York, for a couple of decades, of a social work-based home visitation type of outreach model called Baby Love, which you probably know about, Ian, and we found similar improvements in birth outcomes.

So my question has to do with this sort of

important issue of scale-up in the United States, and how we can take interventions that seem to work on a somewhat small scale -- Strong Start is sort of moderately, but how can we scale it up?

So there are multiple home visitation programs -- Nurse-Family Partnership, many types of home visitation programs. Many of them in their rigorous studies, have found good outcomes, actually, on birth outcomes. Nurse-Family Partnership costs maybe $1,000 per year, but it has had outcomes that now go on for 30 years improved outcomes for kids, that go on for 30 years.

So as programs, as we weigh kind of the benefits of these different -- as Medicaid weighs the benefits of these different kinds of programs and tries to figure out what to invest in and what to focus on, I wanted to ask your thoughts about that. This model is a fundamentally different type of care, with nurse midwifery care, and seems really remarkable. How can that be scaled up? Whereas the other home visitation programs are added on top of sort of the moderately or maybe poorly functioning health system that we had. So these are some of the kind of concerns about the scale-up.

So what are your thoughts about those, how this compares with other home visitation type of models, and where Medicaid should be heading, since obviously Medicaid is the program that takes care of the majority of these women and children?

MR. HILL: So I'll start and then we can hand off. It is a huge challenge. There is so far to go, I think, in terms of getting a more comprehensive access to birth center care and midwifery care. You know, what's interesting to observe about the maternity care home is that model is basically what states have been trying for years to do to improve -- reduce infant mortality and improve birth outcome, layering on top of a clinical model some care management or some nutritional counseling, or what have you.

And I think that what we've found here, perhaps more definitively than any previous evaluation of such an approach, is that if the core intervention is still a short clinical visit, and if the care coordination just layers on top of that a service for women who have really complex needs around housing, nutrition, family planning, breastfeeding, violence, mental health, substance use, and

they are often existing in communities where there are no resources to address those, then there's not much to coordinate and there's not much to refer to.

So I think one takeaway from this is that further investments in that model may not be the best direction to go, even though it's the easiest to implement, right? It would be the easiest thing to layer on top of care in a hospital or in an FQHC.

So one thought -- I mean, one approach certain is for state by state, and maybe with federal guidance, looking at licensure rules, looking at regulations around practice and scope of practice for midwives, addressing -- I mean, Medicare and Medicaid are investing heavily in value-based payments. I mean, there's clearly value in this model. There's lower costs with better outcomes. And so you'd think there would be a strong incentive to pursue innovations in what's covered by Medicaid, leverage MMCO contracting between states and plans.

I think another approach is this notion that there's certainly something magic or unique about the midwifery model and the midwife and their training, but the concepts of focusing on giving more time for a visit,

focusing more on health education, focusing on psychosocial support are things that could be applied in other models.

So I think that's another direction perhaps, but I think it's a huge challenge in terms of scaling.

DR. JAMES: Yeah. I think some of the things that Ian laid out in terms of some of the barriers that we're seeing in the states, I think it is one where we can help to give those states those flexibilities, but it is in terms of the onus and some of the responsibility to help address some of those issues working with the provider associations to help to allow for the nurse midwives to be able to practice, because if we can't address that underlying system to make it more feasible to have that be in place -- we've had in the conversation like how do you expand those birth centers to be able to have that be something, and you start ticking down what some of those challenges are.

I think that we also are looking at additional space where the Innovation Center might be helpful in trying to think about some models of how do we redesign some of the maternal health services to address the needs of communities, but I think that we have some fundamental

challenges that are going to have to be worked out, given that variability, state by state.

Again, just on that rural lens of it as well, thinking about how does this play out in different communities and the different access that we see.

But there are a number of conversations that are happening around this space, and I think some of the others that we have also seen a potential opportunity.

COMMISSIONER SZILAGYI: If I may make one very, very quick point. Maybe a --

CHAIR BELLA: Can I stop you for one second?

We're having a hard time hearing. I don't know if it's the mic system, but if you guys could speak up just a little bit. We don't want to miss anything. Thank you.

COMMISSIONER SZILAGYI: Just a very quick point. I don't want to take too much time. Those are really thoughtful answers, and maybe a very good metric for the overall program would be -- there's not going to be one-size-fits-all. What percentage of pregnant women are actually enrolled in one of these more evidence-based programs and get through one of these programs? So that's a process measure, but if we could at least attain one of

those metrics, I think that will help move us along. If we're starting to follow those metrics, it will sort of raise the bar in terms of what do we need to do to get women enrolled in these programs, whether it is the Strong Start, whether it is a nurse-family partnership, or one of the other home visitations, or one of these really important programs.

DR. JAMES: And I think just to add to that -- can you hear me better now? Okay. It is also thinking about what is the appropriate risk level of who should go in different ones because I think that there's some -- and when we talk about levels of maternity care, some of those high-risk pregnancies, I think there's some questions about which place makes most sense, and how do we address those abilities to triage people where they need to if they're higher risk?

MR. HILL: And if I may just follow up on that particular point, if you try to decipher what's behind state licensure rules or scope of practice rules and some of the tensions between a medical community and a nursing community, one of the core arguments might be that, well, birth centers, those are for all those healthy moms. Those

are for yoga moms. Those are for sort of these dismissive sort of observations that they can't handle, the tougher patients.

This was all Medicaid. These were really high-risk women. They were lower relative in the birth centers than in group prenatal care and especially maternity care home. Birth centers still made the calls in terms of the cases that were beyond their capacity to handle, but these were not low-risk models. So I think that's an important message to get out that might help drive some change at the state level.

COMMISSIONER CARTER: Ian, I believe that the birth center model also reported data on women, even if they didn't deliver in the birth center. If they started prenatal care at that location, wherever they gave birth, their data were included in your report, right?

MR. HILL: That's right.

COMMISSIONER CARTER: In the outcomes?

MR. HILL: In fact, right around half of the births ended up being hospital deliveries, often elected hospital deliveries, but the prenatal care in the center.

COMMISSIONER CARTER: I think that's important.

Thank you.

CHAIR BELLA: Fred, then Sheldon, then Chuck.

COMMISSIONER CERISE: Thank you both. Great. Lots of good information there.

I have a couple of comments. First, you talked about the heterogeneity of the maternity homes, and I think it's an important point. You could argue that the layering of a care manager is a pretty meager intervention when you look at if you are really going to try to change a model there in terms of what's needed and sort of what different places may look like and even a little bit of nutritional counseling. It's hard to argue that that's a really robust maternity home if those were the interventions.

I'll tell you, I come from a place that does about 13,000 deliveries. I'm trying to figure out where we fit in this because we've got like pieces of all of this, with dozens of nurse practitioners, dozens of midwives integrated into kind of a hub-and-spoke model.

So when you talk about scaling, I wonder -- and to try to get at why this doesn't scale, because it seems like what you described, Ian, as the intervention, the time and the attention and the education piece that you're not

going to get from a quick series of OB visits, the concern you'll hear on the medical model side is going to be the complex, the previous pre-terms, diabetes, hypertensive disease, substance use, those things, and how do you scale sort of those specialty interventions or coordinate those interventions with a midwifery or a nurse practitioner model.

So can you talk about how that was handled or is handled in this program?

And then perhaps, in general, maybe either one of you could talk about the opportunities to integrate, because I think the resistance on the medical model side is going to come from those, "Yeah, but what about those, the complicated ones, and how do you handle that?"

We heard a good discussion yesterday about the delivery system model, and when you pull all the important components in, what a difference you can make?

So I'm sure the tension on the midwifery side comes from the concern about those unusual, the rare cases. How was that handled in this program? And then maybe the opportunity to scale and to forge some of those relationships, so that you can scale better.

MR. HILL: Were you asking about how the complex cases were handled in the birth centers?

COMMISSIONER CERISE: In this program itself, you said it was all Medicaid --

MR. HILL: Yeah.

COMMISSIONER CERISE: -- was included.

MR. HILL: Yeah.

COMMISSIONER CERISE: But then you talked about -- I'm not sure what happened in the birth centers, what were referred, and for those referred, what were those?

MR. HILL: Yeah.

COMMISSIONER CERISE: The model I'm familiar with is kind of this hub-and-spoke model where you got those birth clinics that are handled by midwives and nurse practitioners, and then there's a subset that gets referred into an MFM center that gets handled separately. Tell me how this works.

MR. HILL: Sure, sure. So I think that we saw variations in each model. We saw complex medical cases in birth centers being completely referred out or coordinated between the midwifery model and the specialist.

In group prenatal care, they worked hard to try

to keep the complex cases within the group setting, but those women would often have a complementary separate visit with a specialist; and then I think in the maternity care home model, there was more direct access to that approach.

COMMISSIONER CERISE: Again, in all of those, they counted. In the midwifery model, they had to refer relationships. They counted in terms of the outcomes under that midwife model.

MR. HILL: Yes.

I think that the hub-and-spoke -- I think that the notion of layering, I didn't mean to sound dismissive of it as it's sufficient or meager, in any way, because I think there's a continuum of how deep and meaningful those layers were, let's say.

I think what we saw in Strong Start in several cases, first of all, the highest-risk women tended to be in the maternity care home model, and again, our comparison groups were risk-matched. But that is still a baseline.

What we saw that didn't work in that model were things like the care coordinator not having access to the EMR to put notes in, or when they did have notes put in, the docs didn't pay much attention to them. There was not

a routine information flow between the docs doing the clinical visit and the care coordinator who is learning about other things going on in the women's lives.

And then these issues I talked about earlier about in communities that are really resource-poor, there was not much that they could do to help them connect with social determinants.

I mean, I think that the scaling would require a change in mindset in terms of where are the priorities. We've had a medical model dominating maternity care for generations, and there's a very positive movement to focus on social determinants of health. I would argue that evidence from a program like this show that they are probably more important in terms of large-scale improvements in outcomes.

COMMISSIONER CERISE: I would look for success of that. Where it seems like it's more likely to be successful, when you have the groups bought in and working in conjunction, you know, the medical model with the midwifery model in collaboration, not sort of onerous oversight but actually supportive, in a supportive collaborative model. I think when that is well defined,

you have better success and scale on that.

MR. HILL: Yeah, yeah.

DR. JAMES: I'm sorry. If I could just add to that, I like the point of sort of the intersection of all of these. I mean, there is a lot of focus on the social determinants of health and how we're connecting people to those social services, which is getting the medical community and the clinical community to talk to the human service and social services in ways that haven't happened.

I think some of what we have seen and what we have heard, particularly in the maternal space, is around the lack of transfer of information as the woman moves from one place to the next and the fact that that record starts again. So, if there is a second birth and she shows up to the hospital, it's a new patient as opposed to having that information from the previous experience. So, to the extent that we can help to make that information more interoperable, transferrable, and think about how do we incentivize both some of the sharing of that and the collaboration between the different places in which she's touching the system -- and also, when she goes back into the community, there is very little information that's

given back to the primary care provider who will be managing or won't even know what happened when she delivered.

So that, I think, is part of what we also would need to think about how we're doing that and sharing and integrating different parts of the whole team so that everyone does have that insight.

MR. HILL: And, obviously, we haven't talked about payment yet, but I think a key ingredient to scaling is going to be recognizing the value of these services and paying for them and paying for more time and then, again, sort of helping health plans along in terms of recognizing that value in contracting practices and recognizing the value of better outcomes for their bottom lines as well.

CHAIR BELLA: I think that might be where your next comment is going.

Sheldon?

COMMISSIONER RETCHIN: Yeah. Although I do want to say the finding on the birth centers and the value of midwives didn't surprise me. I think we need more midwives in Congress and corporate board rooms. Martha has convinced me of that -- and even astronauts.

I wanted to go back. First of all, this is the second day in a row when we've run up against some scope-of-practice issues, where there are services not adequately provided to rural areas, and those barriers, I think, are very important for the Medicaid program and for the health and survival of rural communities.

So let me get to that and connect the dots back to payment, and that is the obstetrical closures that have occurred. This goes back 15, 20 years. That's been going on for at least two decades, and to me, it must be reaching a crisis level.

I was struck by the fact that it's not just scope of practice issues. It's the fact that MCOs may not even pay birthing centers.

Further, I don't want to blame the victim here, the rural hospitals and the rural communities. I don't know where the blame lines up in terms of payment, but because this has gone on so long, there is, for example, an exemption, I believe, we were talking about yesterday where payment, DSH payments, you have to have two obstetricians on staff. But that's been totally exempted for some or many rural communities, I believe.

I don't want to go back to that, but maybe birth centers could take the place of the DSH requirement. But somehow or another, we need to provide this service going -- there are only 1,800 rural hospitals in the country. If 900 don't offer obstetrical services, that's got to be crisis level.

Anyway, I think we ought to recognize that and come back to -- this is something I'm very uncomfortable with the Commission not addressing this in terms of the payment issue.

DR. JAMES: Yeah. And that information is one of the reasons that we had the forum and trying to pull together. As I like to say, they ask smarter people than me to think about what is that path forward, and so as we look at, you know, workforce issues. So you're not necessarily going to have an OB in every rural community. How are we training our OB residents?

And one of the things that we have seen is there's some interesting and challenging things with regards to rural training, residency programs that focus on maternal and fetal medicine in some of those places, and how are we connecting people to that?

So we have just completed, actually, a list, for lack of a better term, of case studies of talking to some of those rural hospitals to see what they're doing, and it's kind of striking.

Fred said he's coming from an organization that's doing 13,000 -- 1,300 -- 13,000 births a day. We're talking to hospitals that are doing about 200 and on the high end 500. So what that means for ability to participate in quality improvement bundles like AIM or to do training of workforce on what's coming forward and some of the things that they've said, we talk about simulation rooms and simulation models. They have them. They don't have anybody to kind of manage or train the folks on it, and they don't have the ability to send the staff to training because you need somebody to cover what's happening on the floor.

So thinking through, I mean, there are a lot of issues with regards to this, and then how do you leverage the ability of nurse midwives, case managers, the community health workers, who we don't necessarily also reimburse, in some respects, for the care that's provided there to meet the needs? Because it's probably not feasible that we're

going to have a doctor in every one, but what is it that we're doing?

And it's not an issue just for maternal health. I mean, we're hearing the same thing, hospice. We're hearing the same thing in other spaces.

COMMISSIONER RETCHIN: Sure.

DR. JAMES: So a more holistic approach to how we're addressing this.

COMMISSIONER RETCHIN: But I would just emphasize that the focus on obstetrical services, however they may be structured -- and I certainly understand you wouldn't be able to track an obstetrician to a community that had 100 births or maybe even 200. I don't know. Maybe it needs to be regionalized.

But it comes down to payment because the rural hospitals already have negative margins. So it's hard to blame a rural hospital for closing the service, but some regionalization -- because the difference between this and, let's say, hospice or orthopedic surgeon in the community, you get a very low birth-weight baby, and you've got a lifetime of potential costs.

CHAIR BELLA: Chuck and then Tricia.

VICE CHAIR MILLIGAN: This has been a great discussion to listen to.

I actually have a very simple question, Ian, for you, and I think I picked it up in the context, but I want to make it explicit. In the birth center model, when you talk about midwives, you mean nurse midwives, right, not lay midwives? Is that true, or did it include lay midwives? Because that part wasn't clear to me.

MR. HILL: Certified nurse midwives were the dominant provider in these birth centers, yes, but I believe that there were staff that were more mixed as well.

VICE CHAIR MILLIGAN: Dominant but not exclusive?

MR. HILL: Sorry?

VICE CHAIR MILLIGAN: Did the birth center model include lay midwives? That's the part that I'm trying to understand better.

MR. HILL: Please.

COMMISSIONER CARTER: I can help. Some states license what used to be called "lay" or "direct-entry midwives," where they don't have a nursing background, but they are trained and certified by the Midwives Alliance of North America, and I don't know their certifying body. And

they're called "certified professional midwives," CPMs. So some states actually license those people, those types of midwives, and they then practice in birth centers.

VICE CHAIR MILLIGAN: Yeah.

COMMISSIONER CARTER: There's another type of midwife called a "certified midwife," which is essentially equal to a certified nurse midwife. So there are a few CMs. There's CNM/CMs and then CPMs. Yeah, right? Alphabet soup.

MR. HILL: Which is part of why I was unable to answer your question.

VICE CHAIR MILLIGAN: And there I was thinking it was like a yes or no question.

[Laughter.]

COMMISSIONER CARTER: So there are CPMs who work in birth centers. They don't have hospital privileges, and they don't have prescriptive authority in any state that I'm aware of. I could be wrong, but --

MR. HILL: The awardee under Strong Start and the birth center model was the American Association of Birth Centers, AABC.

I can get back to you with more details, if you'd

like, but to the extent that that organization might have certain parameters on member, I could let you know.

VICE CHAIR MILLIGAN: And I'll carry this into when we have the discussion session coming up. The lay midwife, nurse midwife issue has also got its own -- or whatever I should be saying instead of "lay midwife" these days.

COMMISSIONER CARTER: Try CPM.

VICE CHAIR MILLIGAN: CPM. Thank you.

It has its own state-level Medicaid, agency-level issues, licensure, liability insurance, credentialing, but I'll carry that into the discussion to come.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: Yeah, just a quickie, and thank you. This has been really good.

This question is for Cara. Cara, we know that a lot of states are interested in extended postpartum period. Medicaid statute currently says 60 days. The President's budget would have extended that to a year, four months, with substance use disorders, but I would suggest that all moms could use 12 months postpartum. It's good for their health. It's good for the children. It's good for birth

spacing, all of that.

There seems to be some debate in the advocacy community as to whether that could be done under a state plan amendment or would require an 1115 because of the statutory specification of the 60 days. Can you give any insight into what the discussion has been about this in CMS? I'd love to hear that. Thank you.

DR. JAMES: So I won't be able to give a lot of detail about it. We do know that a couple of states have submitted to try and do this, and so the teams are reviewing and looking at that. And that is something that has come up in a number of conversations, given where the proportion of maternal mortality is happening post 60 days and after 42 days. So I think the short answer is stay tuned, but those are definitely conversations that are happening.

CHAIR BELLA: Kit?

COMMISSIONER GORTON: Thanks for great information.

I ask this in complete ignorance. I have no idea, but it sounds like we've talked mostly this morning about facility-based models, hospitals or birth centers.

Is there a role? We have heard from other provider communities at the Commission about the use of telemedicine, about the use of itinerary practitioners, about other models that virtualize care and take the care to where the people are as opposed to dragging the people over the mountain to go to wherever the facility is.

I just wonder, is there a role for this? Is it already in place and it's working wonderfully? Is that part of the scaling issue that we're asking about? I'd be interested in how, whether you call it telemedicine or virtual medicine or, in this case, not medicine -- tele-midwifery and virtual midwifery, if you could just educate me a little bit, I'd appreciate that.

MR. HILL: Do you want to try that?

DR. JAMES: I was going to say that I'm aware of a little bit of that happening but not a lot, and there is definitely interest in that as part of sort of monitoring of women who may be hypertensive, and sort of once they go home, that there is utilization of that. But it varies. Telehealth varies. Utilization varies pretty significantly.

And we still have, in some places, broadband

issues, but there is -- I am aware that some of it is happening, but I couldn't quantify how much of that is happening.

MR. HILL: There weren't any Strong Start models -- weren't any Strong Start sites in any of the models that that really pursued that or had a component like that. I think it's a fascinating idea in terms of the scaling issue for sure.

I'm not sure of the answer. On the one hand, the focus groups that we did, the reports we heard from providers was the importance of this relationship-based care and the ability to work through resistance to sharing sensitive information, trusting, building trust, both among peers and with the practitioners, to be able to really deal with some of these tough issues.

The social worker in me thinks that, oh, well, that has to happen face-to-face because you need that connection, but I don't know that those assumptions are completely right anymore. I mean, I think that -- I've had one video visit in my life, and it was amazing. It was great. I felt like I developed rapport with that primary care doctor very easily.

So I think it's really a good question and would be worth exploring.

I don't know. Martha, do you have experiences with that?

COMMISSIONER CARTER: Well, my experience is within FQHC, and there are barriers to telehealth at the Medicare level with FQHCs, and that sometimes gets carried down to the Medicaid level, depending on the state.

We've used telehealth in prenatal care more for specialty consults. You can pick up the phone and call, but if the OB doc or the maternal fetal medicine specialist can have a face-to-face with a woman while the midwife is there during the visit, then that relieves the woman of the burden of, as you said, driving across the mountain.

So there are definitely applications for telehealth and OB care. I mean, you still need hands on the belly. That part of it isn't going to stop.

But in terms of nutritional, social services, specialty consults, perhaps you need to talk to the family doc because another issue has come up, and again, to have that face-to-face with the patient and if we could resolve the issues with FQHCs not being able to be the distant and

originating site, that would be vastly helpful.

And the Commissioners have heard me rant on this a couple times.

DR. JAMES: The other thing I would add is that we are aware -- South Carolina was actually to implement a couple of virtual centering pregnancy programs, and they actually ended up closing one of them because that, sort of that group model of prenatal care, they found like for the women participating, they didn't find it as valuable and really needed that face-to-face. So I think there are some things that it works for really well and some things where we don't know.

I think the one place we do know it works really well is in the behavioral health space. So, as we're thinking about those visits, telehealth has been critically important in that space, and then from the Medicare side, we've done the analysis looking at Medicare utilization. That is the number one service that people are receiving via telehealth.

CHAIR BELLA: Thank you both, Cara and Ian. Martha, thank you for putting this together.

Because we're sticking on this subject, we're not

going to take a long break. We're going to take 5 minutes to let our panelists leave the front and center. You're welcome to stay for our discussion. We're talking about our work plan for the next 30 minutes or so, and we'll take public comment after that period.

So I want to thank you both. This is an area we're going to be investing time and energy in, and so we may be coming -- we most certainly will be coming back to you with some questions. Thank you very much.

MR. HILL: That would be great. Thank you.

[Applause.]

CHAIR BELLA: So we will reconvene in five minutes, which is 10:55. Thank you.

* [Recess.]

CHAIR BELLA: Martha, whenever you are ready.

MS. HEBERLEIN: Sorry.

CHAIR BELLA: No, no. Go ahead. Thank you for putting together the panel, and we're looking forward to discussing some further work we can do in this area.

FURTHER DISCUSSION AND PRESENTATION OF WORK PLAN

* MS. HEBERLEIN: Great. So thank you all, and I will begin with a brief recap of sort of where we've been

before in this space.

So in June 2013, we wrote sort of a foundational chapter that provided an overview of the role of Medicaid and CHIP in maternity care as well as efforts to improve outcomes, and that overview chapter included information on eligibility pathways, benefits, changes under the ACA, and state and federal initiatives to improve outcomes.

And since then, in April, we released an update looking at payment initiatives specifically to improve outcomes, which focused on bundled payments, blended payments, nonpayment for certain procedures, those sorts of things. And then we also last November issued one of our access briefs looking specifically at pregnant women, comparing their access and outcomes in Medicaid to other payers, and so that's sort of where we've been. And so building on that work, as well as the panel today, we're going to have -- we have a whole proposed plan that touches on a bunch of different issues.

So the idea behind this work is to sort of pull it all together. It could be included in a June report chapter that sort of lays out the issues as well as documents approaches that CMS and the states are taking to

improve outcomes, and it could also set the stage for additional analysis.

So we're sort of beginning with the fundamentals and Medicaid's role in maternal health care. So there are a number of analyses that highlight the ongoing maternal health crisis in the country, but very little has been done on the experience of Medicaid women explicitly. So we're trying to fill the gap in some of that research.

So we have three data analyses that are underway currently. The first is data just to understand Medicaid's role in financing birth. So we are pulling birth certificate data that's going to give us information state by state as to how many births are paid for by Medicaid, where those births occurred, who the attendant was. We'll also get some demographic information.

The second piece of this work is using hospital discharge data to look more closely at maternal morbidity.

And then the third piece of work is we're trying to get a better sense from the CDC mortality data how many Medicaid women have pregnancy-related deaths. So our hope is to bring these analyses to you at the December and January meetings.

The second area of work is an update as well as an expansion on the work that was included in the June 2013 chapter, and under a contract with Mathematica, we're developing an inventory of state-level Medicaid policies that are designed to promote access to and quality of maternity care services for pregnant women. So the catalog is going to include policies related to eligibility, outreach, covered benefits, payment initiatives, managed care contracting, and other initiatives targeted towards pregnant women. And the hope is to bring that to you at the February meeting.

Then the third area of work focuses on substance use among pregnant women. As the prevalence of opioid use disorder as well as other substance use disorders is having serious consequences for both maternal and infant health, we're looking to do some data analysis to better understand the prevalence of substance use disorders among pregnant women in Medicaid as well as their access to treatment. We're also going to be closely monitoring the MOM and the InCK models and looking at initiatives to address both on the state and federal level neonatal abstinence syndrome. And staff anticipate bring the substance use work at the

January and February meetings.

And while prior MACPAC work has shown that OBGs accept Medicaid patients at higher rates than the overall acceptance rate, there are obviously concerns about access to providers, especially in rural areas, as Sheldon brought up. So we're going to draw on this previous work as well as work done by others looking at rural hospital closures, looking at the locations of birth centers to sort of frame up what we can know about provider availability and access to services.

So, finally, as Cara alluded to, a third of the pregnancy-related deaths occur during the postpartum period, and attention has focused on both care and coverage after birth. And as Tricia mentioned, states are looking at extending the postpartum period. There's been some federal legislation being introduced looking at extending it for a year. So MACPAC is going to work to better understand sort of what the various policy proposals might be and what the potential implications are for pregnant women, state Medicaid programs, program costs, as well as other efforts to improve postpartum care.

So, with that, I turn it over to you for more

discussion on the panel and comments on our proposed work.

CHAIR BELLA: Kathy. Thank you, Martha, by the way.

COMMISSIONER WENO: I'd like to make a little comment about oral health and pregnant women. First of all, you know, looking at pregnant women's coverage, especially adult pregnant women coverage in states that don't have a full adult benefit, some states have done a specific pregnant women dental benefit, and in those states particularly, I'm kind of curious about, you know, with access to care issues and difficulty in Medicaid patients getting in to dentists, in a time-limited like a pregnancy benefit, how many pregnant women actually get in to see these dentists during that period is always a question that I have.

But, also, looking at a lot of recent studies that are connecting pregnancy and oral health and low birth weight and that sort of thing, I think it's important for us to look at oral health in pregnancy, especially among the Medicaid population and adults, also keeping in mind that many of the pregnant women are also covered by CHIP and Medicaid. So thanks.

CHAIR BELLA: Brian.

COMMISSIONER BURWELL: In your listing of the data sources, are you going to be using further research? I didn't hear the magic words "T-MSIS." But I assume that the expanded data elements in T-MSIS will eventually provide a lot more information to do work in this area?

MS. HEBERLEIN: Yes. I bang on Chris Park's door all the time to ask him about when are we going to know about pregnant women, and so, yes, that is my top priority for when we get T-MSIS. But as of right now, we haven't looked at those data elements, but we should be able to identify pregnant women much more easily than we have in the administrative data in the past, and so that opens up a whole world of possibilities in terms of where they're getting care, what care they're getting to. I think there's still some managed care issues and bundled payment issues in terms of like can we actually pull out are they getting prenatal care and postpartum visits and stuff like that, which we can cross that bridge when we actually have the data. But, yes, someday.

CHAIR BELLA: Toby.

COMMISSIONER DOUGLAS: So are we also looking at

the point of time when the pregnant women actually get onto Medicaid as part of the analysis, too, just understanding -- because a lot of times they're not getting -- the issue of getting care, prenatal care, is an issue that they don't get on until their second trimester eligible for Medicaid. And so I just didn't know if we've done any analysis around that.

MS. HEBERLEIN: When we did the access brief, the data source we used, the PRAMS does ask what coverage source you had before, what coverage source paid for your prenatal care, and what coverage source paid for your delivery, which is pulled from the birth certificate, and there's been some work by others that has looked at the change sort of between those. We didn't look specifically at the change. We more looked at like the share of women covered and which payer during those particular buckets. So there has been some work. The actual timing is a little fuzzy. We know from that work how many prenatal care visits they got and was it considered adequate, but we don't know like they came on at 27 weeks or they came on at 30 weeks or 12 weeks. Like we don't have that actual timing, to my knowledge.

CHAIR BELLA: Sheldon.

COMMISSIONER RETCHIN: I think this work plan is very exciting and so important to the mission of MACPAC. Just one question and then I guess a comment about the -- well, I certainly think, obviously, the importance of the workforce, so a comment on that.

Probably it would be worthwhile to catalog the scope-of-practice laws by state between, you know, maybe it's more than just restrictive and nonrestrictive, and in that regard, looking at trends over time because some of those restrictions have either eased or maybe even tightened, I don't know. But those are easily obtainable, scope of practice.

Then just a question. I remember in Virginia, I think it was the all-payer claims data, but I'm not sure. They actually had -- on the claims data themselves, the birth weight was captured, do you know?

MS. HEBERLEIN: I don't know on the all-payer claims database. I do know that it's on the birth certificate, and so --

COMMISSIONER RETCHIN: Yeah, sure.

MS. HEBERLEIN: One of the data points that we're

pulling is low birth weight babies, so we will have some of that information, and exactly how we're cutting that I can't remember off the top of my head. But we'll have low birth weight babies. We already sort of know that there are more in Medicaid, but we'll know -- I think we'll know a little bit more by -- probably by state and maybe some rural-urban breaks as well.

COMMISSIONER RETCHIN: And will we also be able to capture the prematurity, the gestational period? Is there a way to do that so we'll know --

MS. HEBERLEIN: That I'm not sure about, but I can look into it.

CHAIR BELLA: Chuck.

VICE CHAIR MILLIGAN: Martha, I think it's a really good plan. I want to follow up on Sheldon's comment and kind of what I mentioned earlier. I think the scope of practice is going to be important to understand, but I would kind of extend it, and my information might be dated, but part of the challenge historically has been access to liability insurance, having admitting privileges, and the relationship of all of that to credentialing in NCQA. And so I would want to make sure that we have kind of those

elements tied off, too, because -- and it may have changed, but one of the barriers had been that some of the stigma, if you will, that we had talked about earlier related to the medical model piece, has translated also into access to liability insurance and credentialing.

CHAIR BELLA: Martha and then Fred.

COMMISSIONER CARTER: You all know this is probably as exciting to me as duals is to Melanie.

[Laughter.]

COMMISSIONER CARTER: And I really thank you for this work plan. I would like to see us come up with some recommendations after we've done our good work and where we feel comfortable in terms of access and payment issues. And I know that may take some time, but I would like for us to be working towards affirmatively making recommendations that the states could implement to improve maternity care.

CHAIR BELLA: Fred.

COMMISSIONER CERISE: Two things. One, in your work around state-level interventions, there are things that may require to go kind of sub-state, I'm afraid, like some of these delivery system programs may not get captured at the state level. And so just as you had somebody

yesterday talk about the duals, I think consider talking to some of the providers that may have models that are being effective.

And then apart from the providers, Peter mentioned the home visitation programs, and full disclosure, I'm on the board at Nurse-Family Partnership, and so I know a little bit about that model. But it may be talking -- those may not get captured at the state-level initiatives either. Some of them are state supported. They're not Medicaid funded. But there is federal funding that goes along with those programs, and some of them have some good evidence for effectiveness, and so taking a look at those may be helpful as well. So that's number one.

And then, number two, real quick, one of the things that we've seen that is kind of a misalignment in this area is in the immediate postpartum period doing long-acting contraceptives and the coverage, they're not -- you can't cover them through 340B because they're done as inpatient, but, you know, sometimes it's going to most effective if you do it right away. And so the practice oftentimes has come back, and then you lose a bunch of people. And so that's one example of a payment

misalignment that we may want to look at. I don't know; there are probably others as well.

CHAIR BELLA: Kisha.

COMMISSIONER DAVIS: I agree, this is a great work plan, and I'm really excited about it. Just as we're looking at access to providers, making sure that we're also thinking about family physicians and the role that they play, and so that interplay, a lot of it comes back to these scope-of-practice issues and credentialing and payment and liability. And so that interplay between OBs and FPs and nurse practitioners and nurse-midwives can factor in a lot.

CHAIR BELLA: I just have a question. In addition to sort of endorsing the importance of this work -- and it looks like a very thorough work plan -- where does state coverage of family planning and what the states are doing, does that fall in sort of the descriptive work as we think about the role of that when we're thinking about access and services?

MS. HEBERLEIN: It certainly could. We're not -- we're capturing initiatives in the state inventory that focus specifically on pregnant women. So where there is a

family planning program that isn't specifically tied to pregnant women and it's more general, like for all child-bearing age folks, we wouldn't be pulling that in. But, you know, Kaiser has been tracking that really close, so we could certainly pull in some of the data they have on the family planning program as well.

CHAIR BELLA: Well, I will give the Commissioners time to formulate more questions and responses. I'll ask if there's any public comment.

PUBLIC COMMENT

* MS. ECKERT: So some of what I have to say has been said, but I'm going to say it anyway for the purposes of being on the record. My name is Emily Eckert. I'm a senior health policy analyst at the American College of Obstetricians and Gynecologists, or ACOG. We are the premier women's health specialty society in the United States representing 58,000 OB/GYNs nationwide. So the comments I'm going to state here are really just to help inform the Commission's work moving forward.

The United States is the only industrialized nation with a maternal mortality rate that is on the rise, increasing 26 percent between 2000 and 2014. Also

concerning, as has been pointed out throughout the morning, are the stark racial disparities in maternal mortality. Black women are three to four times more likely to die from a pregnancy-related complication than non-Hispanic white women. And American Indian and Alaska Native women are 2.5 times more likely to die from a pregnancy-related complication than non-Hispanic white women.

According to the Centers for Disease Control and Prevention, approximately 700 pregnancy-related deaths occur in the U.S. each year, and of these 700 deaths, one-third occur one week to one year after a pregnancy ends.

In fact, 69.4 percent of maternal deaths related to cardiomyopathy occur between seven and 365 days postpartum. Similarly, deaths related to overdose and suicide are now the leading cause of maternal mortality in a growing number of states, and 75 percent of these deaths occur in the late postpartum period. That's beyond 42 days postpartum.

States are hard at work to change this narrative through their Maternal Mortality Review Committees, or MMRCs. The committees are tasked with reviewing maternal deaths, determining what deaths could have been prevented,

and making recommendations to prevent future deaths.

Four states explicitly recommended extending pregnancy-related Medicaid coverage from 60 days to 12 months postpartum in their most recent MMRC reports. These include Georgia, Illinois, Texas, and Utah.

This is the context in which state and federal policymakers have begun to propose extending Medicaid coverage to 12 months postpartum. And in 2019, bills were passed and signed into law in California, Illinois, Missouri, and New Jersey. Additionally, South Carolina was the first state to submit a Section 1115 waiver to CMS seeking authority to extend this coverage.

While this policy proposal is not the only solution to ending preventable maternal deaths, it is foundational. With one-third of maternal deaths occurring in the postpartum period and with nearly 30 percent of women experiencing postpartum coverage disruptions, providing continuity of affordable coverage beyond 60 days postpartum is critically important for new moms on Medicaid.

It's also worth noting that under current federal law, infants born to women on Medicaid are guaranteed

coverage at birth that lasts through the first year of life, regardless of any changes in household income during that period. ACOG encourages MACPAC staff and Commissioners to conduct research and evaluation of this policy and other policy alternatives to give new moms on Medicaid adequate insurance that meets their needs. And I'll just say CHIP also. Thank you, Kathy, for bringing up CHIP. We stand at the ready to help assist however we can.

Thank you.

CHAIR BELLA: Thank you very much.

We have two today. This is great. Welcome.

MS. KOHL: Hello. Thank you all. My name is Amy Kohl. I'm the Director of Government Affairs for the American College of Nurse Midwives. And I really -- I don't have prepared comments but I kind of wanted to respond to some of the discussion in the previous panel.

So our members are, just for the good of the group, we are primary care providers, under federal statute, for women throughout the lifespan, and so ACNM represents certified nurse midwives and certified midwives. And I did want to touch on the comment about the conflation of credentials when it comes to midwifery. It gets very

confusing very quickly at the state level too.

So one of the things that we've been focused on to scale up the number of certified nurse midwives and certified midwives in this country is we have a federal bill right now, Maximizing Optimal Maternity Services Act -- gosh, there's so many MOM acts. But one of the things it would do, it would create some federal funding for certified nurse midwives and certified midwives under the Title 8 and Title 7 of the Public Health Service Act. So this would invest federal funding in accredited midwifery education programs.

We know we have a maternity care shortage, access to maternity care provider shortage in this country, and one of the things that we've been focused on is really building and growing capacity within the midwifery workforce, because we do know, and the data shows that better integration of midwives into health systems does reduce, you know, well, improve health outcomes, reduce the incidence of primary Cesarean sections. And one of the things that we are facing, we have what we call full-practice authority, so the ability to work to the top of our scope in 26 states and the District of Columbia.

Now in 24 states, and if you do the overlay -- so if you look at the high rates of Cesarean sections, high rates of maternal morbidity and mortality, and you look at where certified nurse midwives and certified midwives -- I should say certified midwives, it's a relatively new credential and there are only 111 of them, most of them in New York, so that's a very small portion. So what I'm really talking about here is certified nurse midwives.

But if you do that overlay, it showcases that in the South and in the Midwest, where the rates are terrible, it's where we have a restricted scope, and it is because of things like access to admitting privileges, credentialing, and all number of things, liability insurance.

But I do want to point out, because we do have a great statement of joint practice relations with ACOG, that, you know, ACOG does support us. So we are not trying to care for obstetric emergencies. Our members want to see as many women as possible before it becomes an obstetric emergency. So our colleagues, our physician colleagues, do support us practicing to the top of our scope, and that is something we are also focused on at the state level.

I have lots of follow-up for you all. I want to

say please use me as a reference. I already know, I spoke with Martha and I will be sending some things along to you. But just a comment, and if you have any questions for me I'm here to be a resource. Thank you.

CHAIR BELLA: Thank you very much. Any additional public comment?

[No response.]

CHAIR BELLA: Okay. Kit.

COMMISSIONER GORTON: So I just want to follow up on Something that Cara said, and that Emily said. I know, Martha, you are keeping behavioral health front of mind, but I do think we need to make sure that there is some level of focus on the behavioral health piece. You were talking about these 60 days. If you have a postpartum depression at the end of 60 days it's probably not fixed yet.

And so I do think we need to make sure that we put enough energy into that behavioral health thread, substance use disorder, suicidality, postpartum depression, and then what hasn't been said here but I think we need to add in is intimate partner violence, and look at those things.

I don't know how much that behavioral health bucket contributes to the 700 deaths a year, but I would be interested in knowing how much it contributes to the 700 deaths a year. And, you know, if it's not a big deal, that would be lovely. But I'm guessing that there's probably some light that we could shine on that that might be useful.

CHAIR BELLA: Sheldon.

COMMISSIONER RETCHIN: This question may be for Martha and maybe even some of the public respondents. So one area -- one agency we haven't heard from is HRSA. And so the relevance of that is in terms not only of the workforce but payment. So HRSA has a designation of health professional shortage areas. They declare HPSAs -- and it's based on two different variables, geographic but then the provider type. And there are three provider types -- primary care, mental health, and dental.

As I'm listening I'm wondering why aren't there obstetrical shortage areas -- and again, not -- across different providers, but maybe somebody has an answer to that. But also, I think in the future, as we're talking about this, it would be nice to have someone, if we're

going to have a panel discussion, maybe we ought to think about having someone from HRSA.

MS. HEBERLEIN: So I'm trying to remember. There were a couple of maternal health bills passed last year, and one of them was actually for HRSA to -- it was called Improving Access to Maternity Care Act, that requires HRSA to identify areas that have a shortage of maternity care health providers in order to better align provider placement programs in those areas. So, Sheldon, your wish has been granted.

COMMISSIONER RETCHIN: Well, as long as we're going to do wishes, I have others.

[Laughter.]

COMMISSIONER CARTER: I think our audience -- one of the two of them can probably --

MS. KOHL: Yeah, that's the bill. It was signed into law last year.

CHAIR BELLA: All right. In case anyone didn't hear that, that was the bill and it was signed into law last year. Sheldon knew that. He just wanted to like --

All right. Any additional comments from Commissioners?

[No response.]

CHAIR BELLA: So, Martha, I think you're hearing pretty consistent support and the kind of areas that we're interested in. I know this is a hard area for us to sort of -- it crosses over Medicaid, and so the challenge for us, I think, will be making sure that we're staying to target on that, while recognizing sort of the positive effects Medicaid, as a focus, could have as a ripple effect on the rest of the issue.

So any last comments from any Commissioners on any topic?

[No response.]

CHAIR BELLA: That's a dangerous offer.

All right, before we break, I would like to actually thank the staff, the MACPAC team, and Anne, for another very well-prepared meeting, so thank you all. And thank you, Anne, and thank you, Commissioners, and we are adjourned. See you in December.

* [Whereupon, at 11:22 a.m., the meeting was adjourned.]